PRICED OUT

HEALTH CARE IN CALIFORNIA

JOHN GARAMENDI

INSURANCE COMMISSIONER

2005

CALIFORNIA DEPARTMENT OF INSURANCE

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Acknowledgements and Disclaimer

Between November 2004 and February 2005, I held a series of five day-long health care policy meetings. The purpose of these meetings was to take the pulse of health care in California. I wanted to understand the nuances of current public policy debates and initiatives. I gathered a diverse group of people. Some reinforced my values; others challenged my firmly held convictions.

The group was comprised of some of California's most talented and committed health care experts, including representatives from labor and consumer groups, California legislators and their staff, the principals from major health care trade associations, CEOs and lobbyists from health plans, provider groups and pharmaceutical companies. I am very grateful to the entire group who gave so generously of their time. A list of participants is included as Appendix 2 to this report.

I would also like to thank members of my staff – Nettie Hoge, Andi Biren, Brian Bugsch and consultant Peter Harbage – who served as the principal authors of this report. For much of the information we present we are grateful to the California HealthCare Foundation. It is an invaluable resource to all working in the field.

This report is not a neutral presentation of facts. We have expressly analyzed the information we received in the context of our own values and goals for reform. We have made recommendations at the end of each section. This report and the recommendations contained in it are my views and opinions of those of my staff. In no way are the recommendations and opinions expressed in this report intended to represent any particular views of the participants or of the group as a whole.

Priced Out: Health Care in California
Insurance Commissioner John Garamendi

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Letter from the Commissioner

Priced Out: Health Care in California is my report to Californians on the current crisis in health care. For years we have heard that the system is broken and fragmented. The litany of problems with our health care system is by now a familiar one – high cost, poor outcomes, high and growing levels of uninsured, a fragmented delivery system with perverse incentives regarding quality improvements, rapidly escalating administrative costs that rob health care dollars, a deteriorating safety net, massive cost-shifting and - with shrinking state and federal budgets - no money to fix anything.

Sometimes a broken machine works for a while, but it eventually ceases to function properly or at all. That is the current state of affairs in California health care – headed for complete breakdown.

Since 1966 as a Peace Corps Volunteer in Ethiopia, building clinics and eradicating smallpox, I have worked to expand health care services. As a freshman member of the California Assembly, I authored the Rural Health Act that created clinics in rural California. While Chairman of the Senate Health & Welfare Committee, I wrote laws that created the nurse practitioner program, the emergency medical services and practitioner standards, and set funding for county health facilities. As Insurance Commissioner in 1992, I developed a universal health care proposal that generated national attention and acclaim. I believe that the only way to fix our health care system is to create a truly universal health care program that is based on a single collector of the money, multiple private and public providers, a basic and uniform benefit package, and sufficient information on medical provider quality so that individuals can choose their own provider.

We are not going in the right direction. Instead of bringing health care services to more people, we are pricing more people out. *Chapter One* of this report is a statistical snapshot of the state of health care. The facts and figures paint a clear, but very grim, picture. Costs are exploding. Premiums for private insurance have increased over 60% in the last four years. And this upward cost trend is only accelerating. To cope with these cost increases, employers are dropping coverage for workers, reducing benefits and shifting more costs to workers. Increasing numbers of individuals cannot afford health care, health insurance premiums or cost sharing with their employers.

To respond to the crisis, insurers are offering, and employers and individuals are buying, reduced benefit policies. Without a universal system, the argument goes "something is better than nothing." Comprehensive benefit packages - a consensus of necessary coverage - are in serious danger of becoming extinct. *Chapter Two* discusses the myriad problems with the current trend toward "dumbing down" coverage. Cost savings from such efforts are minimal at best. More importantly, these strategies do nothing to address the serious structural problems in our system which are causing costs to explode and the number of uninsured to swell.

We must get costs under control immediately or our system will break down. We are already well on our way to having an inequitable health care system where the wealthy live and prosper while others are priced out. Forty-five million Americans and 6.6 million Californians can already attest to this. I believe that initiatives aimed at improving health care quality offer great promise for rationally controlling

costs. *Chapter Three* discusses current developments in quality of care initiatives. It is clear to me that the proper deployment of quality measurements, evidence-based practice, and the use of electronic medical records in an environment of ubiquitous health information technology can improve outcomes and control costs. It is time for significant, nationally-coordinated investment in these initiatives.

Chapter Four describes how our public health system is also in crisis. Medi-Cal provides the most cost efficient per patient health care delivery in the country. Public hospitals and public clinics have core competence in health care delivery, treating and caring for the most vulnerable in our population. Forty percent of all births and two-thirds of all nursing home days are funded by Medi-Cal. Yet we are falling further and further behind in our ability to appropriately and adequately fund the public safety net. California's fiscal problems are part of the problem. Another part is the failure of the federal government to be a good partner in efforts to fund the safety net. California ranks 51st in funding per Medicaid beneficiary – behind every state and Washington DC. Federal funding should be equitable and proportional.

Chapter Five considers policy questions surrounding the fastest growing segment of health care costs - pharmaceuticals. Although still only a modest part (11%) of overall health care spending, prescription drug spending has experienced double-digit growth rates in each of the past eight years. Adding insult to injury, US consumers routinely pay 50% to 100% more than those in other countries for many common prescription drugs. Priced out again! Most of the solutions to these problems are in the hands of our federal lawmakers. Once again we need the federal government to step up to the plate.

Chapter Six tackles public health issues and demonstrates why California must firmly commit to protect all Californians and their communities from preventable, serious health threats; assure community-based health promotion and disease prevention activities; and guarantee preventative health services are universally accessible.

At the end of each chapter in this report I include a list of recommendations. In these recommendations, I have tried to remain true to a core principle – short term reforms should be consistent with a long term vision of an equitable and universal health care system where the health and well being of every Californian is our first concern.

The path to universal health care is difficult. In my view, there is no greater problem facing the state of California than the question of how to keep our population healthy on a regular basis, but financially secure in the face of illness. Our future productivity and competitiveness depend on solving this question in a way we can afford. It is a challenge that will require all of our knowledge, cooperation, patience and shared sacrifice. I do not pretend to have the magic bullet. Like many others, I believe that universal coverage is a first step to solving all of the other problems the system faces. I believe a number of good proposals already exist to get us there. (In Appendix 2, I include a matrix of current proposals.) I do believe that while we are summoning resources and conviction to create a universal system, there is plenty to be done that can move us in the right direction. We should take these intermediate steps, as long as they are consistent with our long term objective - health care for all.

This report led me to develop a set of principles to distill the lessons learned from my examination of the state of health care in California. I believe these principles should direct future work in this area. Increasingly, cost is the greatest barrier to access. For this reason, I have formulated the healthcare reform principles set forth below in the context of cost control.

Garamendi Health Care Principles

- **Achieve universal health care.** Universal health care coverage is the only real answer. Shifting the cost of caring for the uninsured onto the private system compromises quality care and makes private coverage unaffordable.

- **Establish a set of comprehensive benefits.** Comprehensive benefits avoid cost shifting and save money in the long run by maintaining the overall health and well being of the entire population.

- **Guarantee fair pricing.** No one should have to pay more because he or she is sick. Fair pricing furthers the goal of universal coverage by spreading financial risk among large numbers.

- **Deliver health care equitably.** Access to quality care should not be determined by income, zip code and race.

- **Reduce administrative costs.** Controlling administrative costs is necessary to expand health care coverage.

- **Improve quality throughout the system.** Quality improvement is the best measure of the effectiveness of health care delivery systems and offers a promising path to cost control.

- **Ensure investment in information technology.** Investment in the full deployment of health information technology and electronic medical records will enable quality improvement and control cost.

- **Value and protect the public safety net.** California's public hospitals and clinics offer core expertise and are integral to the comprehensive and fair delivery of health care services.

- **Demand California's "fair share."** To assure the health of all residents, California needs federal cooperation. California must secure its fair share of federal dollars for public health care delivery programs and demand federal reforms that control pharmaceutical costs.

- **Use interim reforms to further the long term goal of universal health care.** Health care reform proposals must align short term reforms to long term objectives. Recognizing that plans to expand public financing are challenging, all interim steps should be consistent with a long term comprehensive solution.

Chapter 1: The State of California Health Care
California's Health Care Crisis

Some of the world's best doctors and nurses practice in California. The state's hospitals and research centers enjoy a reputation for being at the forefront of technology and innovation. People come from all over the world to receive high quality health care in California.

Despite California's health care reputation, the system is in trouble – serious trouble. Too many people in California pay far too much to access life-saving care. Insurance coverage is shrinking while premiums are increasing at unsustainable rates. Administrative costs are increasing so rapidly that they are eating away at dollars that should be available for patient care. Physicians are overtaxed with administrative, billing and collection efforts, while insurers and health plans continue to consolidate and reap growing profits. Cost-shifting to private payers for underfunded safety net medical facilities is accelerating with no sign of slowing. Hospitals are closing and starving for adequate sources of revenue.

In this environment too many people have no access at all. Too many with chronic conditions go without needed care. And far too often, the most predictive factors in defining access to quality health care are income, zip code and race.

In 2005, the United States will spend 15.6% of its total economic output, an estimated $1.9 trillion, on health care, a higher rate than at any other time in US history. But are we getting our money's worth? No, and we know it. Research released last year indicates that the majority of Americans (55%) are dissatisfied with the quality of care they are receiving, up from 44% just four years earlier. Furthermore, 40% believe the quality of health care in the United States has worsened over the past five years, compared to only 17% who believe it has improved.

Is all this spending making the US healthier than other countries? No. Other industrialized countries spend far less than the US, yet they have longer life expectancy and lower infant mortality rates. The World Health Organization ranks the US near the bottom of many health indicators.

Similar to the nation as a whole, the state of health care in California is on a dangerous path. Costs continue to rise at an unsustainable rate, placing heavy financial burdens on individuals, business and state and local government. Escalating health care costs continue to swell California's legions of uninsured. Those who forgo needed care often end up in emergency rooms at public hospitals requiring taxpayers to pick up the tab for the most expensive care available.

The answer to these challenges for some is the "ownership society." This approach includes association health plans (AHPs) and so-called "consumer-driven" health care products. These short-sighted solutions have the potential to hasten the deterioration of the already badly broken system.

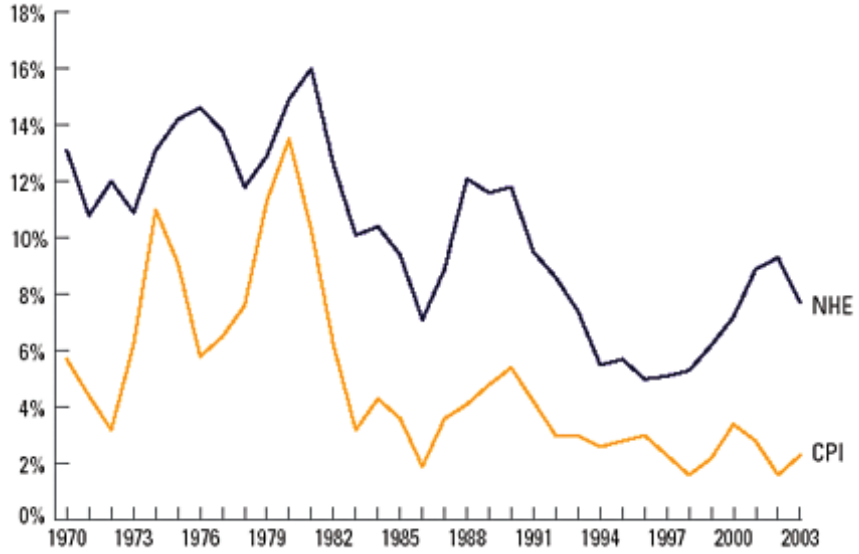
The introduction section to this report provides an overview of the state of affairs in US and California health care. It is intended to be a snapshot of health care –how much it costs, who has access, and what the health indicators tell us. It is followed by subsequent sections detailing the opportunities and challenges for health care in California.

The National Context

The United States spends more money today on health than at any time in our history. The statistics are breathtaking. In 2003, national health care spending totaled $1.7 trillion – 4.3 times the amount spent on national defense. Health care costs are projected to double to $3.6 trillion and account for 18.7% of GDP by 2014.

- ***Health care costs continue to grow at rates 2 and 3 times that of inflation.*** Since 1970, the growth in health care expenditures have consistently exceeded inflation. Health care spending per capita is 16.3 times higher today than it was in 1970, while inflation is only 4.7 times greater than 1970 levels.

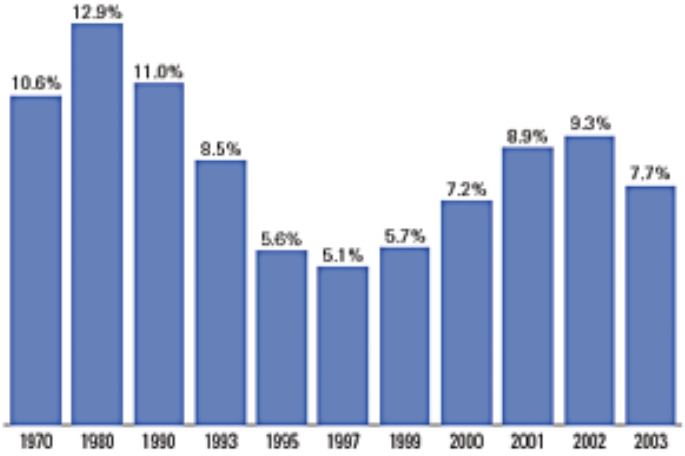
Growth in Health Care Spending Versus Growth in Inflation



Source: Health Care Costs 101, 2005 – California HealthCare Foundation
Blue Line is National Health Expenditures (NHE)
Yellow Line is Consumer Price Index (CPI)

- ***Health costs are growing at a rate not seen since the early 1990s.*** Health care spending slowed briefly in the mid-1990s, most likely due to the growth of managed care. Since 1996, spending has again accelerated. Although far outstripping inflation, the 7.7% growth in health care costs in 2003 marked the first deceleration in health care spending in seven years.

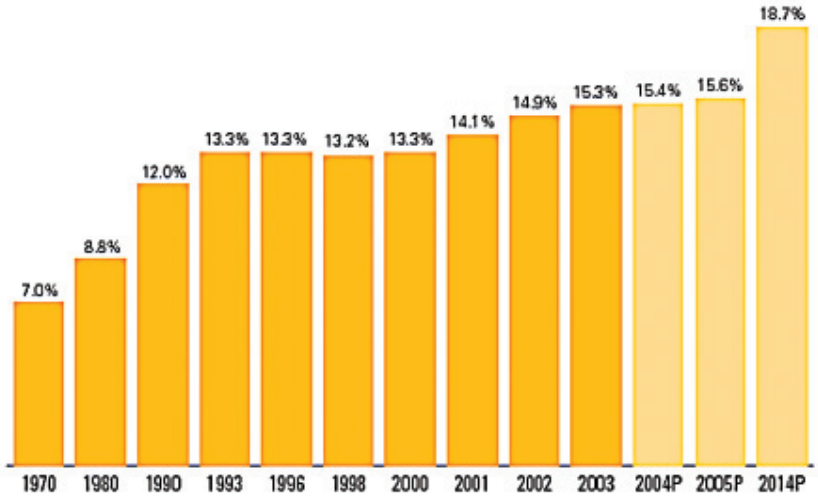
Average Annual Growth in U.S. Health Care Spending



Source: Health Care Costs 101, 2005 – California HealthCare Foundation

- ***Health care spending consumes a greater percentage of America's economy than ever before.*** The tremendous rate of growth in health care has led to a growing percentage of the economy being devoted to health care. Over the 30 years from 1970, health care spending has more than doubled as a percentage of Gross Domestic Product, rising from 7% in 1970 to 15.3% in 2003.

Health Care Spending as a Percentage of GDP



Source: Health Care Costs 101, 2005 – California HealthCare Foundation

- ***The major cost drivers in health care spending are administrative costs and prescription drugs.*** As we all pay more, the natural question is where does the money go? Again, the national data is clear.

  - *Administrative costs were the leading cost driver in 2003.* Health care administration costs continue to grow unabated. Administrative costs have risen $101 billion over the past 20 years. In 2003, administrative costs increased $14 billion or 13.2%, totaling $119.7 billion. According to a 2003 New England Journal of Medicine study, administrative and other non-medical care costs accounted for 31 cents of every dollar spent on health care in the US in 2003, compared to only 17 cents in Canada.

  - *Prescription drugs continue to be the fastest growing segment in health care spending.* In 2003, prescription drug costs increased 10.7% or $17 billion, marking the eighth consecutive year of double-digit growth. Over the past two decades, US spending on prescription drugs has increased tenfold, growing from $17 billion or 4.9% of spending in 1983 to $179 billion or 11% of spending in 2003.

  - *Home health care costs are rising as well.* In 2003, home health care spending increased $4.2 billion or 9.5%. Although home health care only accounted for 2% of national health care expenditures, the $40 billion spent in 2003 was nearly 10 times larger than 1983 levels.

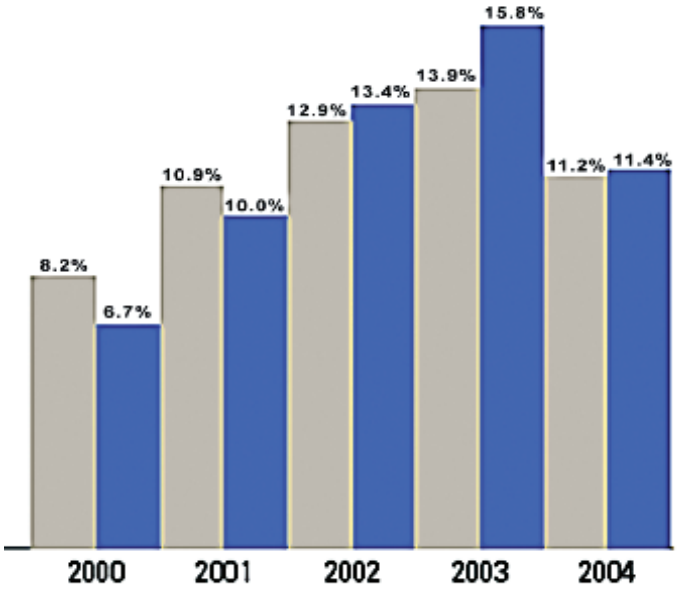
Crisis in Health Insurance: Skyrocketing Health Insurance Premiums

To help fund the increases in health care spending, insurance companies are raising insurance premiums both nationally and in California.

- ***From 2000 to 2004, health care insurance premiums increased 61% in California – with double-digit increases each year.*** Premium increases in California have outpaced the rest of the country for each of the past three years. More importantly, this double-digit annual premium growth far outstrips the national growth of inflation, which averaged around 2% annually over the same period.

- ***In 2004 alone, California health insurance premiums increased nearly 7 times faster than inflation.*** In 2004, California health insurance premiums rose a budget busting 11.4%, in contrast to a modest 1.7% rise in California's inflation rate.

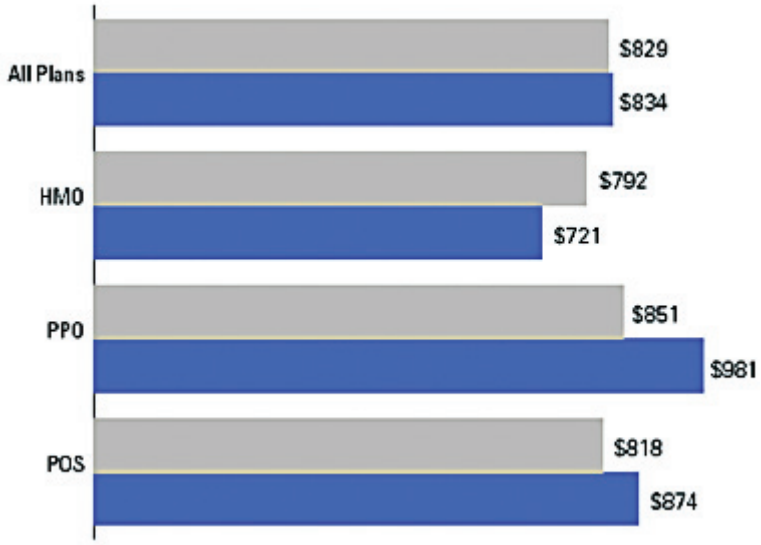
Annual Growth in Private Health Insurance Premiums, US and California, 2000-04



Blue = CA; Gray = National
Source: Health Care Costs 101, 2005 – California HealthCare Foundation

- ***California families pay $1,500 more per year for PPOs than the rest of the country.*** Although health insurance in California costs only slightly more than the US average across all health plans, PPO plans are significantly more expensive in California than the US average. A PPO plan for a California family of four on average costs $11,772 annually.

2004 Monthly Health Insurance Premiums for Family (US and California)



Source: Health Care Costs 101, 2005 – California HealthCare Foundation

Crisis in Health Insurance: Paying More for Reduced Coverage

Although California-specific data is limited, national trends clearly demonstrate that those fortunate enough to have employer-sponsored insurance are paying more for health insurance that covers less.

- ***Americans are paying more out-of-pocket than ever before for health insurance.*** As employers struggle to keep up with rising health care costs, more and more costs are being shifted to employees. In 2003, annual out-of-pocket costs averaged $779 per person.

- ***Deductibles and copays are on the rise for everyone, limiting access to health care.***

  - Nationwide, the average annual deductibles for a non-HMO family coverage plan has gone up from $580 in 2000 to $861 in 2004, an increase of almost 50%. Most other insurance products went up by comparable amounts, if not more.

  - In California, the percentage of covered workers in HMOs paying a $20 copay for physician office visits has increased from 3% in 2001 to 14% in 2004. For a $15 copay, the percentage has grown from 15% in 2001 to 27% in 2004. This growth is even larger nationwide.

  - By contrast, the percentage of covered workers in California in HMOs paying a $5 copay for office visits has fallen dramatically from 30% in 2001 to 7% in 2004.

- ***More people are paying premiums.*** The shift in health insurance premium payments is profound.

  - In California, the percentage of premiums paid by workers for a family plan has increased from 23% in 2000 to 27% in 2004.

  - Nationally, the percentage of firms that cover 100% of the employee's share for family premiums was cut in half from 14% in 2001 to 7% in 2004.

  - For employer-sponsored coverage, the percentage of policies with a total monthly insurance premium of $950 or more for family coverage increased from 2% in 2001 to 20% in 2004.

  - By contrast, the percentage of employer-sponsored coverage insurance policies with a total monthly premium of $550 or less for family coverage dropped from 38% in 2001 to 5% in 2004.

- ***More firms are reducing their benefits.*** Last year, 15% of large employers reported reducing their health care benefits from the previous year.

- ***Prescription drug coverage is being reduced.*** While nearly everyone who has employer-sponsored health insurance (99.9%) is offered a prescription drug benefit plan, the cost of that coverage is going up.

  - The percentage of US workers offered tiered drug benefit coverage (plans where there are progressively higher copays for generic drugs, formulary drugs, and non-formulary drugs) increased from 27% in 2000 to 65% in 2004.

  - Nationwide, the copay in tiered drug benefit plans for non-formulary drugs has doubled from an average of $17 in 2000 to $33 in 2004.

Health Costs and the Economy

High health care costs are eroding California business competitiveness. In fact, a survey by the California Business Roundtable found that the cost of health care is the top concern for the CEOs of America's largest companies. Forty-three percent of CEOs surveyed ranked rising health care costs as their number one concern. Litigation ranked number two with only 20% of CEOs listing that as their top concern. A February 2005 Duke University/CFO Magazine Business Outlook survey of CFOs in major corporations worldwide discovered that 65 percent thought it was very important for Congress to address the costs of health care, on par with concern over budget deficits and well above concern for social security reform. Fifty-three percent of CFOs thought health care was a top issue and expected health care costs to increase 9 percent in the coming year.

- ***Rising health care costs are a burden for manufacturers.*** General Motors, the world's largest automaker, spends $5 billion a year on health care costs, with future cost obligations estimated at more than $60 billion. In 2004, GM spent $1,525 on health care for every vehicle it produced.

- ***The US spends a much greater portion of private dollars on health care than any other country***. The US government also spends more on health care than the governments of most other industrialized countries. In 2002, the US government spent $2,364 per capita on health care (primarily Medicare and Medicaid), while the governments of Canada ($2,048) and France ($2,080) spent less.

- ***Poor quality health care reduces worker productivity.*** The NCQA (National Committee for Quality Assurance) found a total loss of 66.5 million work days in one year due to poor-quality care, for just five health care conditions. This is equivalent to losing 293,000 workers from the economy at an estimated employer cost of $9.6 billion.

Condition	Sick Days
Asthma	22.6 million
Depression	10 million
Diabetes	6.8 million
Heart Disease	5.7 million
Hypertension	21.4 million
Total	66.5 million

Source: NCQA

Crisis in Health Insurance: Growing Uninsured Overall, Greater Reliance on Public Safety Net

As the price of insurance goes up, fewer people are able to buy in. And as the cost of health care skyrockets, the number of uninsured in California is charting a similar path. California faces a greater challenge than the rest of the country because a lower percentage of California employers offer insurance.

- ***Fewer California businesses offer insurance than elsewhere in the US.*** As compared to the rest of the country, California has historically relied more on publicly-financed health programs and continues to lag behind the rest of the country in offering employer-sponsored health coverage. Although the gap between California and the rest of the country has narrowed recently, California businesses have a long way to go to catch up.

Employer-sponsored health insurance coverage in the US and California, 2002
(% of the nonelderly populations)

	1987	1993	2002
US	70.1%	64.3%	64.2%
California	61.0%	53.2%	59.6%

Source: US data - Fronstin, December 2003 (analysis of CPS data); California – Current Population Survey (CPS) data.

Sources of health insurance coverage, US and California, 2003
(% of the nonelderly populations)

	US	California
Employer	63%	59%
Public Insurance	12%	14%
Uninsured	15%	20%

Source: B. Strunk and J. Reschovsky, Trends in US Health Insurance Coverage, 2001-2003, Center for Studying Health System Change Tracking Report #9, August 2004 (Community Tracking Study Household Survey).

- ***The number of uninsured in California continues to rise.*** Overall, the number of people without health insurance in California increased from 6.3 million in 2001 to 6.6 million in 2003.

  - California has one of the highest uninsured population rates in the country, with more than 21% of the non-elderly lacking coverage.

- More than 50% of all the uninsured in California, 3.7 million people, were without any coverage for all of 2003.

- About three-quarters of California's uninsured live in households with a full-time worker.

- ***Rates of health insurance vary significantly by race.*** In 2003, approximately 6% of Whites were uninsured for the full year in California. By contrast, Latinos (21.9%), American Indian/Alaska Natives (14.6%), Asian Americans (9.6%) and African Americans (8.1%) had significantly higher rates of uninsurance.

- ***The good news is that more California children have health insurance.*** One bright spot is that more California children had health insurance in 2003 than in 2001. California's health care advocates, county and state health staff should be proud of their success. Where the private sector has failed, the public sector was able to come together and protect the health of children.

  - In 2001, there were about 1.5 million children under age 19 who were uninsured. By 2003, this number had dropped by more than 25% to 1.1 million uninsured children in California.

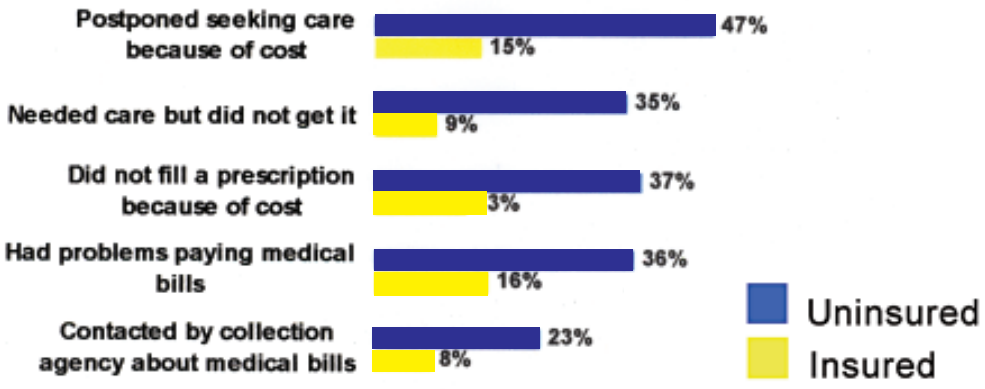
  - Even though enrollment of children in employment-based insurance dropped 4.3 percentage points over this time period, Medi-Cal or Healthy Families coverage for children increased 5.2 percentage points.

What Happens to the Uninsured?

- ***Being uninsured puts people at a tremendous disadvantage.*** People who lack health insurance do not get preventive care, tend to wait longer to seek treatment for illness and generally suffer worse health outcomes for similar illnesses than people who have health insurance.

  - There are an additional 2,500 deaths per year in California due to uninsurance.
  - Hundreds of thousands of others suffer poorer health and reduced productivity.
  - It is estimated that nearly half of all bankruptcies in the United States are due to unpaid health bills.

Impact of Uninsurance, 2003



Notes: Experienced by the respondent or a member of their family. Insured includes those covered by public or private health insurance.

Source: Kaiser 2003 Health Insurance Survey.
Taken from slide presentation: UCLA's Center for Health Policy Research, "Access to Care and Health Care Disparities in the Golden State," undated.

Health Status is Declining in California

Insurance is a critical part of health care in the United States, but it is still only one part of the system. Health indicators are the true measure of the success of California's health care system. Unfortunately, the statistics demonstrate that we could and should be doing much better.

- ***Obesity has reached epidemic proportions. It seriously compromises quality of life, is a significant drag on the economy and adds staggering costs to the health care system.***

  - Obesity is a major risk factor for a multitude of diseases, including heart disease, certain cancers (breast, colon), stroke, diabetes, depression, and arthritis. Nearly 80 percent of all obese adults have diabetes, heart disease, hypertension, or high blood cholesterol. It is the second leading cause of death and results in 30,000 deaths annually in California. (California Obesity Prevention Initiative)

  - Obesity cost California $21.7 billion in 2000 in direct and indirect medical costs, lost productivity and workers' compensation – with $7.7 billion accruing directly to Medicare and Medi-Cal. Nationwide, obesity costs the health care system an estimated $118 billion per year. Being overweight increases annual per person health care costs by $125. Obesity increases the number by $395. (Finkelstein, Fiebelkorn, and Wang, 2003; www.ca5aday.com; CA Endowment)

  - The prevalence of overweight Californians (BMI >25) has risen from 38% in 1984 to 57% in 2003. More than 4.7 million adults in California were obese (BMI >30) in 2001 and the number continues to rise. Almost half of California women (45.2%) and about two-thirds of men (63.4%) are overweight or obese.

  - Overweight and obesity effects all ages, ethnic groups, education and income levels. However, the rates of overweight and obesity are especially high among African-Americans (70.4%) and Latinos (69.6%) in California. Rates were also highest in urban Los Angeles and the rural Central Valley. (California Behavioral Risk Factor Surveillance Survey, 2003)

  - In California, 24% of children age 12-17 are overweight or at risk of being overweight, with Latino and African American kids having much higher rates of obesity than White and Asian kids. Another study determined that 26.5% of California students are overweight and 40% are unfit. (California Center for Public Health Advocacy, 2002; CA Endowment)

- ***Diabetes affects millions, increasing costs and lowering quality of life.*** Nationwide, 6.3% of the population or 18.2 million people have diabetes. In California, approximately 6.5% of adults, or 1.7 million people, had diabetes in 2003, and another 2 million are at risk of developing the disease at some point in their lives. (California Dept. of Health Services, Feb. 2005)

- The total economic cost of diabetes in the US in 2002 was estimated at $132 billion or $1 of every $10 spent on health care. This was comprised of $92 billion in direct medical costs and $40 billion in indirect costs. (American Diabetes Association)

- Diabetes rates vary significantly by race with African Americans (20.5%), American Indians (19.6%) and Latinos (17.9%) having significantly higher diabetes rates than Whites (8.3%) among adults ages 50-64 in California. The results are comparable for adults 65 and over, with the rate for Whites (12.2%) at half of that for African-Americans (25.6%) and Latinos (24.4%).

- ***Asthma affects millions —increasing costs and lowering quality of life.*** 924,000 or 10% of California children suffered from asthma in 2002, above the 9.2% national average. (Carolyn Mendez-Luck et al, Asthma among California's Children, Adults and the Elderly: A Geographic Look by Legislative Districts, UCLA Health Policy Research Brief, September 2004. Children & Asthma In America: A Landmark Survey, 2002.)

- ***Infant mortality in ethnic areas of California is double the national average.*** While California (6.1 deaths per 1000 births) has a slightly better infant morality rate than the rest of the country (7 per 1000 births), ethnicity and zip code once again have a significant impact on health outcomes. The Crenshaw neighborhood of South Central Los Angeles has an infant mortality rate of 13.8 per 1000 births. Latino babies in Kern county have infant mortality rates of 12 per 1000 births. (Erin McCormick and Reynolds Holding, Too Young to Die, San Francisco Chronicle, Sunday, October 3, 2004)

California Faces Unique Challenges in Public Health Care Funding Including Lack of Federal Support

Without a comprehensive national or state-level policy to ensure universal access to health care services, the public hospitals and health clinics form the cornerstone of California's public health safety net. But this safety net is unraveling beneath unbearable pressures. Demand for health care services from the uninsured continues to grow while resources for the publicly-financed safety net shrink.

Revenue and resources available to counties and local government to provide public health resources continue to fall short as federal, state and local governments struggle to keep pace with the steeply rising cost of care. Hospital financing, earthquake retrofitting requirements, nurse staffing ratios, and federal threats to pare back Medicaid funding all create strong economic pressures on an already overburdened and dysfunctional system. These burdens fall disproportionately on the safety net's core consumers – low income, uninsured, and people of color.

- ***California receives fewer Medicaid dollars per beneficiary than ANY other state.*** For every beneficiary on Medi-Cal, the state receives (on average) $2230. This is less than half of the top ranked state and well below the national average.

- ***The federal government has threatened to make additional cuts in Medicaid.*** Instead of expanding support of state governments, President Bush's FY2006 budget proposal seeks to cut $60 billion from Medicaid over 10 years by tightening eligibility requirements and placing more restrictions on state reimbursement.

- ***California's safety net is underfunded.*** As health costs continue to rise and revenue streams continue to dry up, California's public hospitals and health systems face estimated budget shortfalls of at least $3 billion from 2002-07.

- ***In 2002, LA County closed 16 health centers and made other cuts in an attempt to address a projected $700 million budget shortfall.*** LA county hospitals and clinics serve 800,000 patients annually. This population is 63% Latino and accounts for one-third of the state's uninsured population.

- ***Public hospitals account for 6% of hospitals in California, yet they provide 55% of care for the uninsured.*** California public hospitals provide $1.6 billion in uncompensated care annually. In addition to bearing the burden of caring for the uninsured, public hospitals operate 62% of the state's top-level trauma centers and train half of the state's doctors.

- ***Cuts to the public safety net disproportionately disadvantage the poor, ethnic minorities and the uninsured.*** California's public hospital patient population is 76 percent people of color, including 50 percent Latino.

Health Care Quality and Cost Containment

One of the most promising areas for improving health care is the current focus on health care quality. Improving quality has potential cost control benefits. Reducing unnecessary spending and refocusing resources on effective prevention and treatment would reduce cost and improve outcomes.

- ***If all Americans received care through high-performing health plans, it is estimated that the health system would have saved $1.8 billion in 2004.*** The National Committee for Quality Assurance (NCQA) was able to estimate that thousands of people would have avoided adverse health events. This was done using HEDIS (Health Plan Employer Data and Information Set) data and assuming the health outcomes as if all health plans performed at the 90% quality level.

MEASURE	AVOIDABLE (NON-FATAL) EVENTS EACH YEAR	AVOIDABLE COSTS FOR HOSPITALIZATION, ETC.
Beta-Blocker Treatment	600 heart attacks	$6.1 million
Breast Cancer Screening	7,600 breast cancer cases treated in Stage IV due to late diagnosis	$48 million
Cholesterol Management – Control	14,600 major coronary events	$87 million
Colorectal Cancer Screening	20,000 cases of colorectal cancer diagnosed/treated at a later stage	$191 million
Controlling High Blood Pressure	7,600 strokes 15,900 major cardiovascular events such as heart attacks	$463 million
Diabetes Care – HbA1c Control	14,000 heart attacks, strokes, or amputations	$573 million
Smoking Cessation	Smoking-attributable health care expenses for 272,000 smokers	$441 million
Osteoporosis Treatment	2,100 subsequent fractures	$7.2 million
	Total Health Costs	**$1.8 billion**

Source: NCQA

- ***Health plans could have avoided 42,000 to 79,400 deaths, if all health plans were at high performing levels.*** Using the same methodology as above, the NCQA estimated the number of annual avoidable deaths.

MEASURE	AVOIDABLE DEATHS (Annually)
Beta-Blocker Treatment	900 – 1,900
Breast Cancer Screening	600 – 1,000
Cervical Cancer Screening	600 – 800
Cholesterol Management – Control	6,900 – 17,000
Colorectal Cancer Screening	4,200 – 6,300
Controlling High Blood Pressure	15,000 – 26,000
Diabetes Care – HbA1c Control	4,300 – 9,600
Flu Shots for Adults over 65	3,500 – 7,300
Prenatal Care	600 – 1,400
Smoking Cessation	5,400 – 8,100
Total	**42,000 – 79,000**

Source: NCQA

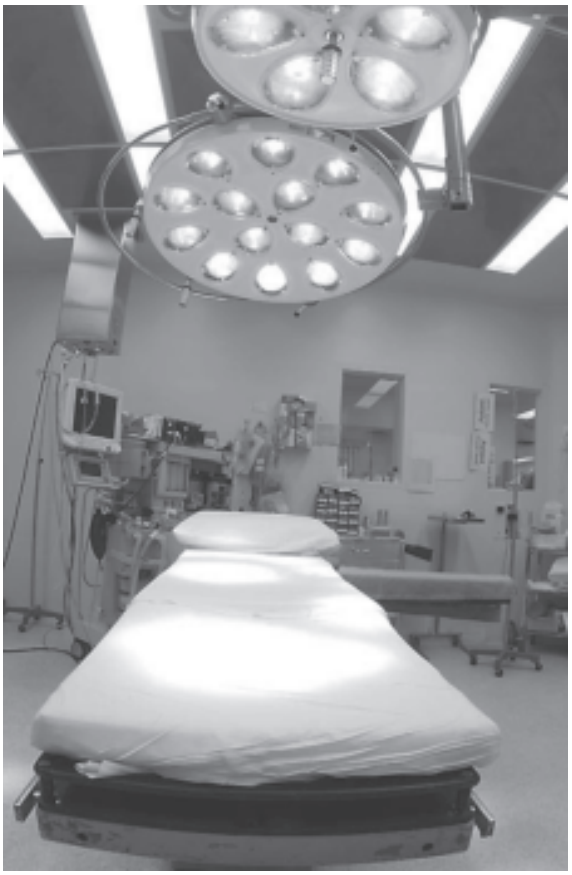
Chapter 2: Benefits and Cost-Sharing

The State of Health Care Benefits and Cost-Sharing

- The federal government recently projected that health care spending will double to $3.6 trillion in the next decade, consuming 18.7 percent of the nation's economy by 2014.
- Employers and consumers have experienced cumulative increases in health care premiums of more than 60% over the past four years.
- In response to increased medical costs and increased premiums, many employers have eliminated or reduced health care insurance benefits and increased employee cost-sharing.
- In 2004, there were approximately 5 million fewer jobs providing health insurance than in 2001.
- Fewer California businesses offer health insurance to employees than elsewhere in the US (59.6% versus 64.2%).
- In the year prior to July 2003, 44% of California employers increased employee cost-sharing.
- The average annual health care insurance premium for a California family was $10,008 in 2004.
- The average employee share of premiums for a family in California was $2,580 in 2004.
- Median household income in California in 2004 was $48,979 and the minimum wage on an annualized basis was $14,040.

History and Use of Minimum Benefit Packages

Health policy analysts approach benefit design from different perspectives. In the context of advocating for expanded or universal coverage, a set benefit package will define the floor and guarantee equitable coverage. It is also the essential ingredient for total program cost analysis. For many employers, benefit design is a cost control strategy. Legislators and policymakers try to find the perfect blend of care for preventive, routine and chronic health needs that is inexpensive enough to make expanded access more economical and thus achievable.



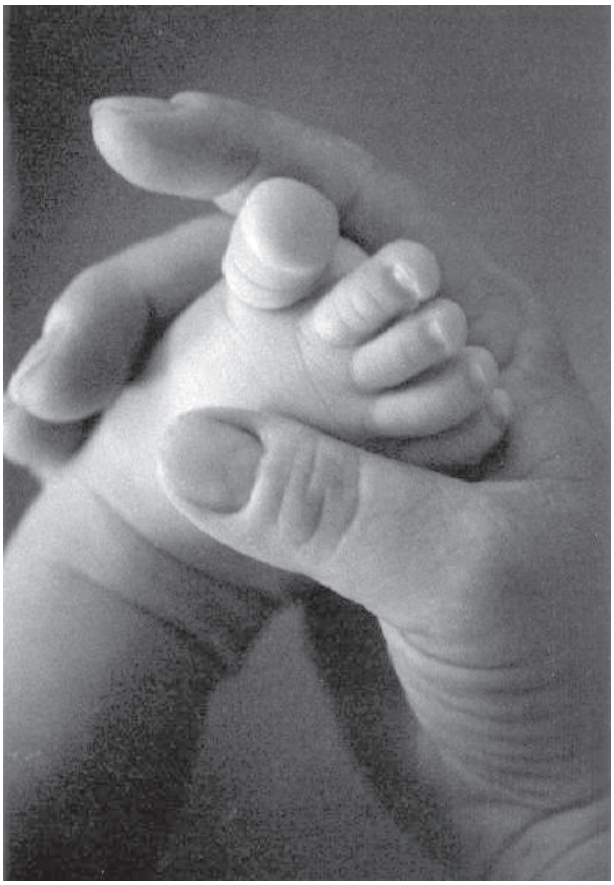
In California, which has historically been dominated by HMOs, Knox-Keene Act benefits (Health and Safety Code Section 1345) have established the de facto minimum benefit floor. The Knox-Keene benefits package is a fairly comprehensive set of benefits that cover seven key areas: (1) Physician services; (2) Hospital inpatient services and ambulatory care services; (3) Diagnostic laboratory services; (4) Home health services; (5) Preventive health services; (6) Emergency health care services; and (7) Hospice care. Prescription drugs are conspicuously absent from this list of required benefits. However virtually all HMOs offer this benefit and almost all employers purchase it. Required benefits under Knox-Keene are ultimately determined by the "medical necessity" of any given service. Health care providers must ensure that the services provided are medically necessary and consistent with criteria and guidelines supported by clinical principles and processes.

Over the last three decades the benefit package has been supplemented by legislatively imposed "mandates" and "mandates to offer." These have been grafted on to Knox-Keene requirements, and added to insurance policies covering medical care and hospitalization regulated by the Department of Insurance. These legislative developments have led the two, health insurance products (CDI) and health plans (DMHC), to more closely resemble each other. As evidence of this, the proponents of employer mandate legislation in 2003 agreed to allow either benefit standard as the floor for requirements of employer provided health benefits, with limitations on cost-sharing through co-insurance and deductibles.

However, there are some differences between insurance products and Knox-Keene controlled managed care products that are likely to become increasingly significant. Historically, the California Department of Insurance (CDI) has approved larger deductibles and co-insurance. Products sold at CDI are not subject to the mandate to cover maternity costs. Since hospitalization is not required as part of a plan offered through CDI, much leaner policies are possible. In the current environment, where many believe reduced benefits are the only way to contain costs, there may be greater demand on CDI to approve new so-called "consumer driven" products.

Specialized products can lead to risk selection and subsequent underfunding of higher risks, especially when the product is exclusively aimed at saving money. The poster child for these problems is a new Blue Cross product marketed as TONIK to 18 to 24 year-olds, known as the "young invincibles." Different tiers of TONIK, such as "part time daredevil" and "thrill seeker", enable Blue Cross to offer various pricing options under this policy umbrella. The most controversial aspect of the product is its exclusion

of maternity care. The cost of a routine healthy delivery (vaginal birth, no complications, 2-day hospital stay) in California ranges from $6,500 to $9,500 and the cost escalates dramatically with a Caesarean birth or other complications. It is predictable that many in the young invincible category will require coverage at some point, causing them to migrate at least temporarily into more comprehensive policies or into Medi-Cal and AIM (Access for Infants and Mothers).



Savings resulting from cutting coverage have been minimal at best - estimated to range from zero on the low end to 6.5% on the high end over a three-year period. They are static savings. Once the cuts are made, no additional cost savings accrue from year to year. To generate further savings requires further limitations on benefits. To the extent that limitations in benefits or increased cost-sharing results in patients forgoing necessary treatment, leaner coverage limits may end up increasing costs in the long run or transferring costs to the public sector.

Emerging Trends

Regardless of the limited potential for long-term savings, benefit trimming is being pursued by employers and promoted by some policymakers. The trend is to adjust cost-sharing by either shifting more financial responsibility onto the individual without substantively altering benefits or leaving premiums alone and reducing benefits.

In addition to affordability, a stated rationale for cost-sharing is cost-control through reduction of utilization. Advocates of this approach argue that making the individual more responsible for their own health care costs will give them “skin in the game” and produce better purchasing decisions. Advocates for this approach justify it by pointing to managed care’s alleged failure to effectively use gatekeepers and utilization review to limit services.

However, the logic is flawed. Patients dealing with an illness are ill-equipped to analyze and respond appropriately to such pressures. Cost-sharing, or more accurately cost-shifting, is a blunt instrument for containing costs. It places equal constraints on patients seeking necessary and unnecessary care. Expensive and complicated treatment that could have been prevented with early detection and intervention may be the unintended result. In addition, comparative information that would allow consumers to compare choices based on value are not available.

Greater cost-sharing by individuals is clearly unsustainable. More than half of all bankruptcies in the US are due to health care costs and three-quarters of individuals declaring bankruptcy for health reasons were enrolled in health insurance. Below are a variety of approaches to cost-sharing and benefit trimming that have emerged.

Health Savings Accounts (HSAs) are personal tax-free accounts set up by employees or employers to pay for health care spending not covered by an insurance policy. The accounts belong to employees regardless of who sets them up. HSAs are set up with federal tax deductible contributions of up to $2,600 for a single person and up to $5,150 for families. The accounts must operate in conjunction with a qualifying High Deductible Health Plan (HDHP). Eligible HDHPs include an annual deductible of at least $1,000 per individual and $2,000 per family. Total annual out-of-pocket contributions through co-pays or deductibles cannot exceed $5,000 per individual or $10,000 per family. HSAs may be set up so the individual contribution required does not apply to preventive care. HSAs were established partially in response to slow acceptance of the more restrictive medical savings accounts (MSAs) which require higher deductibles and provide fewer tax advantages. The tax advantages make HSAs attractive to high income people.

High Deductible Policies are becoming more common and the Department of Managed Health Care (DMHC) has even started to see applications for deductible policies in the HMO area. Higher deductibles simply shift more costs onto the insured by requiring greater out-of-pocket contributions for medical treatment received.

Health Reimbursement Arrangements (HRAs) are the "defined contribution" of employer provided health care coverage. Under these arrangements, employers establish an individual reimbursement level of a fixed dollar amount for each employee. These are often provided in conjunction with a high deductible insurance product. HRAs are called arrangements not accounts because only employers can contribute. They do not earn interest and are not portable from employer to employer. As of late 2003, HRA enrollment was between 300,000 and 400,000 nationally and participation in California has been slower than in other parts of the country.

Customized Packages - In these designs, employers make a fixed contribution toward premiums and the employee can choose among products with different benefits and prices. Choices include various provider network options and benefit packages with different levels of coverage. Customized packages are far more common in California than are HRAs and they are most frequently offered by small and mid-sized firms because they work more effectively with only one carrier.

Employer Group Initiatives - Various large employers or groups of large employers have been spearheading initiatives aimed at increasing access to coverage for hard-to-cover populations such as part-time and seasonal workers. For example, HRPA (Human Resource Policy Association) is a group of senior HR executives from more than 200 of the largest employers in the country promoting initiatives aimed at increasing access. The program they have put forth necessarily involves new benefit designs, since there is little or no employer contribution and the plan is designed to serve populations that are typically lower income. Under this initiative, employers contract with an insurer who is committed to offering a set of benefits at a negotiated price. The packages range from very basic plans with a limited

number of physician appointments to more comprehensive plans including hospitalization. Deductibles vary and access to prescription drugs are tiered. Employees receive the benefit of group policies, and thus get the benefit of guaranteed issue and guaranteed renewable policies without pre-existing condition exclusions.

Association Health Plans (AHPs) legislation pending in Congress combines many of the worst aspects of all of the so called "consumer-driven" models. Proponents of AHPs attempt to justify them as a way to make insurance more affordable for small groups. The argument is based on the misconception that if small employers form larger groups they will find better bargains for health insurance. In reality, AHP legislation is designed to bypass all state regulation of minimum benefits, underwriting restrictions, solvency oversight, fraud and consumer protection. Associations could form under almost any pretense and operate across state borders, free from any state's oversight. Because of "cherry picking" and compromised solvency standards, their existence would cost society more in the long-run. Current legislation relies on Department of Labor enforcement which historically has been notoriously ineffective. Furthermore, proposed legislation provides no additional resources to oversee an enormous new regulatory function.

Long Term Impacts of Consumer-Driven Plans

All of these initiatives are attempts to provide something to populations that might not otherwise be covered. As such, they appear to the general public as possible policy solutions. But ultimately, these policies are nothing more than stop-gap responses to the problems occurring in a system that has not committed to universal coverage. Thus they are symptoms of a worsening situation, not solutions.

Expanded availability of these plans in the marketplace would likely exacerbate problems inherent in our fragmented system in a number of ways.

- ***Puts the entire health insurance system at risk.*** Plans driven by consumer choice, such as HRAs, HSAs, and other customized plans will necessarily create adverse selection. Healthier younger employees will have new incentives to opt for less expensive plans, leaving sicker and older employees in more traditional and more comprehensive insurance plans. This will drive up costs, leading to more cost shifting, more selection bias and leaner plans, creating what some refer to as the insurance "death spiral." Inevitably such a spiral will lead to more uninsured, resulting in increased cost shifting onto insured consumers and accelerating the spiral's momentum. In addition, it is possible that more people will be driven out of the private health insurance market toward public insurance programs and safety net systems, placing additional pressure on already burdened state and local government.

- ***Causes patients to forgo needed care.*** The supporters of consumer-driven products assert that "empowering" patients to make decisions about their care will help control costs by creating incentives to seek out high-quality, low-cost care. Yet financial disincentives are likely to cause many to forgo necessary treatment at early stages when early detection and intervention would allow less expensive and more effective treatments. Furthermore, as is discussed elsewhere in this report, there is no uniform system for evaluating health care quality –either in California or the United States. Making patients responsible for identifying

quality care may be an appropriate goal, but the health system does not supply the information necessary to allow patients to make educated decisions. As a result, there is no evidence that such products will lower costs or improve quality.

- ***Increases cost-shifting.*** Doctors are already deserting certain practices and hospitals are abandoning certain geographic regions because reimbursement rates are so low. Those remaining will likely be hit with increasing levels of uncompensated care as they try to collect high deductibles and charge consumers for costs that exceed the limits of leaner plans. Additional provider expense will be incurred collecting increasing levels of bad debt.

- ***Exacerbates loss of benefits.*** In the absence of a mandated benefit floor, existing coverage levels may continue to deteriorate. And as leaner benefit packages catch on, there may be a stampede toward these products because of the promise of initial cost savings. In an environment of increasing consolidation, more limited competition and little government oversight over rates, the savings will dissipate and the new floor may be lower, but equally expensive.

- ***Makes the health system more complex.*** Many of these new products will add additional layers to the health care system's already expansive and costly administrative bureaucracy. Providers may need to deal with an even more complex and confusing array of payor arrangements. New TPAs and benefit managers may be required to set up and administer new plans, siphoning off even more of the health care dollar to non-health care expenditures.

- ***Results in inefficient use of resources.*** HSAs, MSAs and HRAs cost more money and only serve to create a more inefficient system. It is estimated HSAs will cost the federal government $7 billion in lost tax revenue over the next 10 years. These resources would be spent more effectively if they were used to help fund a universal health care system.

- ***Increases inequities in access.*** Many of these plans favor and will be used predominantly by upper income individuals. Public resources expended in these programs, in the form of tax advantages, do not address the central problem of uncompensated care represented by those who simply cannot afford full coverage and cannot take advantage of the tax incentives they offer.

Recommendations

- Establish Knox-Keene benefits plus prescription drugs as the common benefit floor for all HMOs and health insurance policies sold after approval at the Department of Insurance. Conduct a public review of the impacts of consumer-driven plans. The benefit floor cannot be breached until we understand the implications of the consumer-driven plans.

- As a condition of contracting with the state of California, employers must, at a minimum, provide a "Knox-Keene plus prescription drugs" or equivalent comprehensive benefit package to all employees.

- Strengthen rate review with emphasis on reviewing administrative expenditures.

- The federal government should reimburse qualifying companies and insurers for 75% of the portion of any claim exceeding $50,000. By creating federal reinsurance for catastrophic claims, premiums could be kept more affordable for businesses and individuals without compromising comprehensive benefits.

- Require hospitals to calculate and disclose on each bill they issue, the percentage and dollar amount of cost shifting for uncompensated care incorporated in the final charge that is associated with each billed service.

Resources

Health Savings Accounts: The Fundamentals, Beth Fuchs and Julia James, NHPF Background Paper, April 2005, http://www.nhpf.org/pdfs_bp/BP_HSAs_04-11-05.pdf

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Hazardous Health Care: The Impact of Savings Accounts on Minnesota Health Care – A Report to SEIU Local 113, Sally Covington and Tom Moore Jr.

Health Care in California: Perspectives from Employers and Consumers, California HealthCare Foundation, 2005

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Chapter 3: Improving the Quality of Health Care

The State of Health Care Quality

- Quality is being diminished by **under-use** and **over-use** of medical treatments, by **failure to provide care** and by **providing the wrong type of care**.
- Between 44,000 and 98,000 Americans die from medical errors every year *(IOM study)*.
- 45% of the US patient population does not receive the recommended treatment.
- 11% of the US patient population receives care that is not recommended or is harmful.
- 75% of diabetics are not adequately monitored for glucose control.
- 50% of x-rays for back pain patients are unnecessary.
- 50% of heart attack victims fail to receive beta blockers.

Issues, Challenges and Opportunities

Systemic health care quality improvements will significantly improve health status and control costs. The first hurdle to improving health care quality is achieving a consensus on how to measure it. Subsequent challenges include:

- adoption of evidence-based medical practice;
- deployment of universally accessible information technologies; and
- realignment of incentives for treatment from our current system that rewards only volume to one that rewards compliance with best practices and measurable improvements in quality.

Government entities, functioning as payors and regulators, are uniquely positioned to hasten quality improvements. Government can:

- facilitate adoption of interoperable technologies;
- realign incentives through reimbursement practices;
- support deployment of resources through funding priorities; and enforce performance standards through licensure.

Assessing Quality

The health care quality improvement agenda begins with a quantifiable assessment of the status quo. Once benchmarks are established and measurement tools adopted, improvement in health care quality can be tracked and providers can be compared to one another. Dissemination of comparative information to payors to design compensation packages and to consumers to inform choice will drive improvements in the system.

The primary challenge for assessing quality is that there is a lack of consensus on how to measure it. At present, there are a vast array of health care report cards and quality indexes for hospitals and provider groups. One option is for all health providers to adopt the limited national performance index for hospitals and office care. Fortunately, a number of efforts are underway, including:

- *Federal Efforts.* On the national level, the Centers for Medicare and Medicaid Services (CMS) has just launched HospitalCompare, a website that compares participating hospitals on performance related to pneumonia care, heart attack and congestive heart failure. CMS, in conjunction with the American Medical Association's Consortium on Performance Improvement, has developed a set of clinical quality measures for physician office-based care. These can be compared without confusion.

- *Efforts by California Hospitals.* The California Hospitals Assessment and Reporting Task Force (CHART) has been working since January 2004 to reach consensus on performance measures for California hospitals. Once agreement is reached, each hospital or hospital system will be asked to formalize its commitment and pay for data collection and submission to CHART II, the database manager. The health plans would be required to refrain from making their own hospital report cards public, but the CHART performance measures would be available on their websites.

- *Efforts by California Physicians.* California physicians, with the input of patients and hospital workers, should build upon the CMS measures. Then, Medi-Cal, California health insurers and HMOs should gather data from their contracted providers based on those measures, allowing for an apples-to-apples comparison between health plans.

- *Efforts by Purchasers.* Some organizations may wish to go beyond whatever minimum performance standards are established. So, for instance, a group purchaser of healthcare, such as CALPERS or collective bargaining partners, may ask health plans to impose higher quality standards on their contracting hospitals and physician groups as a condition of contracting with them.

Evidence-based Medicine

In many ways, the practice of medicine continues to be more art than science. But, one of the latest developments in health care quality is the use of evidence-based medicine (EBM), treatment based upon the best available information relating to outcomes, efficacy, and safety. The emergence of EBM is a response to significant clinical variation in the treatment delivered to patients who suffer from the same medical conditions.

EBM identifies the best evidence on treatment options through comprehensive analyses of outcome statistics and use of large-scale studies. Perhaps the most essential aspect of effectively implementing EBM is ensuring that EBM protocols are universally available to providers. Various tools are being developed to accomplish this task, including published guidelines and interactive computer programs. Health plans and insurers have a central role to play in disseminating information on evidence-based medicine and information technology tools can greatly facilitate that process.

EBM supporters encourage the use of consistent, efficient, scientific guidelines for treatment decisions. Emphasis on preventive care and effective management of chronic conditions, such as asthma and diabetes, can improve quality of life for patients and reduce their need for higher cost emergency procedures. Well-accepted protocols for heart attacks and maternal care demonstrate the future of medical practice. For some conditions, there is broad consensus on "best practices" and even "centers of excellence" based on these practices. To the extent there are high-grade studies indicating comparative benefits of one procedure or modality over another for a given condition, the physician should use the effective procedure or modality. Indeed, the case for evidence-based medicine is clear.

- *Treatment varies with geography.* Medicare claims data show significant variation in courses of treatment depending primarily upon which region of the country care is given. No medical rationale exists for these variations.

- *The US health system pays per procedure, a perverse incentive to promote quality care.* As a result, it seems likely that Americans are being subjected to more procedures at a greater cost with no positive impact on health outcomes. According to a 2002 survey, twice as many coronary angioplasties are performed in the US as in any other country. The US has nearly twice as many MRIs per capita as the median across industrialized countries. It seems unlikely that such large differences merely reflect a higher standard of care.

- *EBM can be about providing more care.* Many patients are not receiving inexpensive routine diagnostic tests that could improve outcomes and save money through early intervention.

The significant challenges to effectively implementing evidence-based medicine are many.

- *Physician Autonomy and Discretion.* For guidelines to be useful, doctors must be aware of and motivated to follow them. A national survey of U.S. pediatricians indicated that while nearly 88

percent were familiar with asthma guidelines, only 35 percent followed them. EBM dictates a new way of practice which will involve overcoming inertia and habit.

- *Differing Quality of Evidence*. There are numerous, but sometimes conflicting, resources for identifying the best evidence. Furthermore, individual patients may have multiple conditions that complicate implementation and effectiveness of various treatment protocols. One challenge for improving quality is educating physicians to discern the differences between high-grade peer-reviewed studies based on a large data set and a single small sample test.

- *Inequitable Resource Distribution*. While a health care system like Kaiser has sufficient data and resources to craft evidence-based treatment protocols, smaller groups do not. In addition, geographically remote areas, public safety net physicians and hospitals, and small medical practices may not have the time or the resources to systematically introduce quality evidence into their practice routines.

- *Standardization*. Some warn that treating according to a rigid evidence-based protocol will undermine the inherent innovative possibility in different approaches to treatment and treat patients interchangeably. The warning would be valid if anyone advocated treating only according to EBM. Rather, evidence-based medicine requires that ineffectual treatments not be used and proven treatments be used unless there is an articulable fact-based reason why they should not be used. Therefore, clinical judgment must be used before prescribing. There is ample room for different approaches in the many conditions for which there is not clear evidence concerning effective and ineffective treatments, and in the infinite permutations of presenting symptoms, medical history and physician's clinical judgment.

- *Little incentive*. Incentives for doctors and hospitals are misaligned. Much of the initial investment in practice change will be required from health care providers, yet successful implementation of EBM may reduce their volume-based reimbursements.

Statewide agreement upon, and universal implementation of, an initial limited group of evidence-based "best practices" – and an incentive to follow them – will guarantee improvement in the quality of services throughout California's health care system.

The Role of Information Technology

Dr. David J. Brailer, National Coordinator for Health Information Technology, has set and publicized an impressive list of goals for effectively deploying medical technology:

- Introducing information tools into clinical practice;
- Connecting clinicians electronically;
- Using information tools to personalize delivery of care; and
- Advancing public health surveillance and reporting for population health improvement.

However, there are significant hurdles to clear before a national system of health information technology is in place. Although the creation of a national standard requiring interoperability of technological systems is a giant step forward, implementation may still be difficult.

- *Time, Money and Competition.* Health care systems that have already invested in "teching-up" may not be eager to open up proprietary systems which now provide a competitive advantage. The cost of "teching-up" is a prohibitive factor for many public hospitals and smaller medical practices, as is the time and money required for educating providers to use the systems and convert current records and data into new systems.

- *Providers face perverse incentives.* With information technology improving quality and leading to fewer and more effective treatments, practitioners who are paid per unit of care delivery may have an incentive to avoid information technology. This is not an insubstantial issue. Technology investments are likely to benefit health plans, but it is the providers who are expected to make initial investment in both capital and resources. In exclusive closed panel HMOs, like Kaiser or some county plans, investments and benefits are shared equally. Barriers to inducing health plans to significantly invest in technology for their physician networks are significant. Often voiced is the fear that substantial investments will benefit competitors who also make use of the same physician networks (free rider problem). Creative and cooperative systems of allocation might address this problem, but it must be addressed.

- *Complex legal issues.* Questions also need to be answered regarding who owns the electronic medical record (EMR) of an individual and who can access it and input data. The EMR must be portable and accessible to the patient, while simultaneously ensuring the patient's medical privacy. It must also be secure from a data integrity standpoint.

However, the opportunity for EMRs to enhance healthcare quality is significant.

- *EMRs will provide immediate and complete information on a patient's health history* and prescriptions for the physician making health care decisions. The advantages of EMRs are most apparent in life-threatening emergency room situations where a doctor's immediate intervention on behalf of the patient is required. Knowledge about allergies, current medications, complicating secondary and related diagnoses, although essential, is often not available. The patient may be unconscious, incoherent, or unaware of his or her own health status.

- *Reduce clerical errors.* Computerized physician drug order entry (CPOE) eliminates handwriting errors, allows drug interactions or allergies to be flagged and unusual dosages to be identified and questioned.

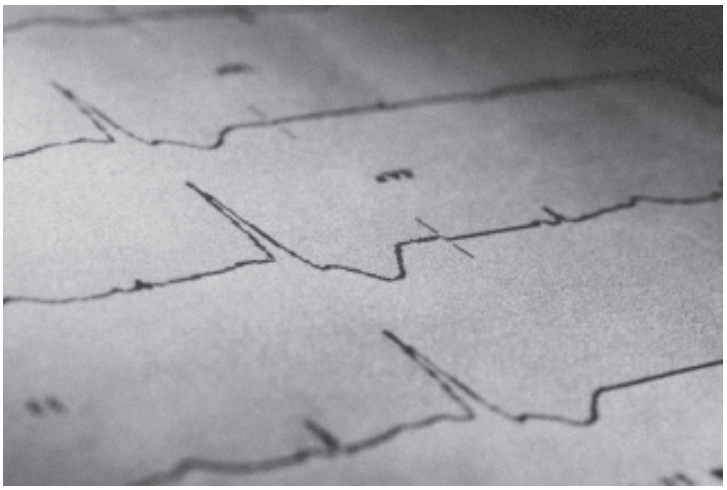
- *Eliminate duplicate tests.* Duplicate tests, historically required when a patient changes doctors or because the chart cannot be located, become unnecessary.

- *Better care in rural areas.* Rural patients can have a doctor at a distant facility review their EMR and provide consultation. "Best practices" can be available online for instant reference.

Fortunately, California is already working toward EMRs. In tandem with the national health technology effort, Regional Health Information Organizations, like CalRHIO, are emerging. These organizations can foster local, regional, and statewide health information projects. The ultimate goal is to assure that California has an integrated, efficient electronic system to securely share patient information between health care providers at the point of care. RHIOs can help facilitate, or actually develop, certification standards for technology so investment is not wasted. Once certification standards are adopted, a CalRHIO, in addition to other roles, could serve as a conduit for low-interest loans for groups of physicians to purchase hardware and software.

Widespread EMRs allow aggregation of treatment and outcome data from multiple provider systems. This data can identify effective and efficient treatments for conditions that do not occur in credible numbers in smaller pools of patients. The evidence-based medicine protocols of the future reside in this data. Government will be essential to assure that data collection efforts are broadly representative, non-proprietary and accessible for widespread use.

A statewide system of treatment and outcome data collection by a licensee of the Department of Insurance and the Department of Managed Health Care could be established. Insurers and HMOs are in a good position to collect from their provider networks data on treatment efficacy, in addition to cost and claims data. Licensing of insurers and HMOs could be premised on participation in and funding of the data-collecting organization. A governing committee, including representatives of healthcare consumers, could determine what data should be requested and extracted. This information would be available to medical researchers, as well as all participating insurers, HMOs, providers and the state agencies. Ultimately, some of the data could be shared directly with the public through health websites. A partial pilot of this system could be commenced now with hospital discharge data, detailing conditions, length of stay, charges, and treatments.



Pay-for-Performance

In current private medical practice, bad physicians are perversely rewarded for poor outcomes through payment for multiple office visits from sick patients. Conversely, good physicians are penalized for efficiently healing their patients. Pay-for-performance programs attempt to overcome this perverse incentive and improve health care quality by financially rewarding doctors who follow best practices and achieve positive medical outcomes.

But there are many challenges in implementing a pay-for-performance program. In developing such programs, payors should be careful to account for the following:

- *Lack of a level playing field among providers.* The lack of consistent, uniform quality measures limits comparisons and can significantly hinder implementation of pay-for-performance strategies. The dissemination of tools and information necessary to make pay-for-performance effective is likely to proceed unevenly throughout communities in the state. This could contribute to a tiered system of health care, where tools to enhance quality are not equally available to all providers. In an environment where reimbursement is predicated on use of technology and information tools, community clinics and providers serving the safety net may suffer even more.

- *Role of patient behavior.* A physician's treatment is only one part of the equation. Positive health outcomes also depend upon patient compliance with and responsiveness to prescribed medical treatment. Financial incentives that are intended to be positive reinforcement for quality work could have the unintended consequence of encouraging doctors to drop their non-compliant and unhealthy patients.

- *Providers must be involved in developing pay-for-performance programs.* If pay-for-performance programs are to have a chance of succeeding, they must be well-designed and physicians must be involved in a cooperative manner. Kaiser Permanente avoids many potential pitfalls by paying a salary, but providing bonus opportunities for meeting certain benchmarks, including timeframes for initial visits and completion of treatments. Incentives can be offered for following evidence-based protocols, regardless of outcome. Bonuses can be paid for improvement over time on both cost and quality indicators. Patient satisfaction can be surveyed as an element of a bonus formula. When technology is available, bonuses can be paid for using it, so that time "lost" on data entry is still compensated time. Health plans and insurers should implement payment plans that will properly align incentives on issues such as long-term disease management, successful home health care programs, and education efforts.

Expand the Number and Role of Nurses

California's hospitals, surgery rooms and doctor's offices would all grind to a halt without a trained, motivated and dedicated nursing workforce. Nurses play an indispensable role in the delivery of quality health care. Every day they are called upon to compassionately deliver highly technical care. Studies confirm the importance of nurses and the necessity of assuring that each nurse can focus on essential tasks and is not overburdened. A New England Journal of Medicine article found that adding just one

patient to a nurse's caseload increases the odds of a patient dying by 7%. High patient-to-nurse staffing ratios lead to increased levels of cardiac arrest, pneumonia, shock, upper gastrointestinal bleeding, urinary tract infections and extended hospital stays.

Despite the critical role nurses play in the delivery of high-quality health care, California and the rest of the nation face a serious nursing crisis. Every year 500,000 registered nurses leave the nursing workforce. The overall demands of the profession - low pay, long hours and unsafe work conditions – have conspired to make it even more difficult to recruit young talent. The number of new registered nurses graduating from college dropped 26% from 1995 to 2000. The need to meet new nursing staff ratio requirements is making it even more imperative that we address this issue immediately.

Recommendations

- Require licensure standards for health facilities, both public and private, to include participation in data collection efforts, quality assessment programs, 'best practice' programs, and other quality incentives.
- Endorse and facilitate compliance with the national standard for Health Information Technology by funding CalRHIO.
- Within 10 years, provide EMR capability in all medical settings and revise any laws or other barriers that would hinder an insurer from providing hardware and software to providers.
- Create subsidies for small medical practices and safety net providers to assure that they remain on even footing with larger segments of the medical community in implementing quality initiatives and deploying information technology.
- Review and revise regulations for health care facilities to require the use of evidence-based medicine.
- Establish a pay-for-performance program within Medi-Cal with appropriate financial support for subsidies for providers to gain access to necessary tools, technology, and information.
- Assure nursing staff ratios are met and expand the use of nurses throughout the industry.
- Involve nurses and nurse practitioners in the development of quality standards.
- Expand community college and university nurse training resources.
- Reward nurses and encourage entry into the profession with adequate pay and other incentives.
- In conjunction with DMHC, license a data collection point for PPOs and HMOs to aggregate data on treatment and outcomes.

- Approve discounts or credits by medical malpractice insurers for physicians with CPOE and EMR capabilities.

- Seek legislation to require PPO CEOs to adopt a common set of quality metrics for PPOs and to participate in CalRHIO.

Resources

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Chapter 4: Medi-Cal Reform

The State of Medi-Cal Reform

- Medi-Cal, California's state Medicaid program, provides insurance to 6.6 million low-income individuals.
- One in six Californians under age 65 receive health care through Medi-Cal.
- Nearly one in four of California's children are on Medi-Cal.
- Medi-Cal covers the majority of people living with AIDS and it fills gaps in Medicare coverage for the low-income elderly and people with disabilities.
- Since FY 1998-99, the Medi-Cal budget has grown 60% and there has been a 32% increase in the number of people receiving care services through the Medi-Cal program.
- Medi-Cal spending is projected to exceed $34 billion in 2005-06 and more than double over the next decade.
- Medi-Cal pays for more than 40% of all California births.
- Medi-Cal pays for two-thirds of all nursing home days and accounts for two-thirds of all public hospital revenue.

Since 1966, a year after President Lyndon Johnson signed Medicaid into law, Medi-Cal has been at the heart of the California health care system. Regardless, every budget cycle we are told Medi-Cal is facing a crisis.

Instead of repeatedly accepting periodic crises in Medi-Cal, it is time to admit that Medi-Cal is facing many of the same systemic challenges that are eroding the entire health care system. Medi-Cal's rapid growth is a direct result of the failure of the employer-based system to provide adequate coverage.

In addition, Medi-Cal's inadequate funding contributes to cost shifting that hastens the demise of the private system. State leaders need to move beyond the mindset that Medi-Cal just needs a quick fix - that a benefit cut here or a premium increase there could actually fix the system. In fact, shared principles are needed to guide reform that will help realize a long-term vision.

Background

Medi-Cal, California's version of the Federal Medicaid program, will spend $33 billion on benefits this year, with the federal government paying the majority of the cost. This figure represents California's second largest expenditure behind K-12 education. Medi-Cal accounts for 15 percent of General Fund spending.

Over time, Medi-Cal has become an exceedingly complex program that is nevertheless essential to its beneficiaries. Some think of Medi-Cal as a "welfare program", but the majority of people under 65 enrolled in the program are from families with a working parent. No discussion of reforms can begin without considering several basic facts:

- *Medi-Cal plays a major role in California health care*. Medi-Cal is critically important to California health care, accounting for $1 out of every $6 spent on health care in the state. California's public hospitals receive two-thirds of their revenue from Medi-Cal. Any policy shift will have profound impact on California's medical providers.

- *Medi-Cal serves a significant number of people in the state, and in many cases the most vulnerable*. Fourteen percent of California's population is enrolled in the program, second only to New York at 15%. Medi-Cal pays for more than 40% of all California births and the program covers one in four California children. Half of all Medi-Cal dollars are spent on the aged, blind, and disabled population (ABD). As a result, any policy shift will affect a significant portion of society's most vulnerable people.

- *California receives fewer federal dollars per beneficiary for Medi-Cal than any other state.* The federal government paid California about $2,250 per beneficiary in 2001. In contrast, New York received almost $5,500 per beneficiary in 2001. Because there is limited capital to fund major policy shifts, Medi-Cal's ability to make reforms is severely limited.

- *For all the criticism of Medi-Cal, it is the workhorse of the health care system*. California covers more people for less money than any other state in the nation. Medi-Cal is expected to provide a continuum of services in society. The program pays for emergency room services to the undocumented who need care, covers breast and cervical cancer services for women, and pays for routine vaccination to children.

Principles for Medi-Cal Reform

Every year, many of the same ideas for Medi-Cal "reform" are re-introduced regardless of the administration. In Capitol circles, it's called "round up the usual suspects." What is needed is a set of guiding principles for policymakers and legislators evaluating policy ideas reforming Medi-Cal. The following principles would be a good start:

- *Maintain the entitlement nature of the program*. Society has already committed to the obligation to provide the most vulnerable with health care through Medicare and Medicaid. These two programs are structured as entitlements so that everyone who qualifies receives the same set of comprehensive services. Any effort at reform must maintain this entitlement

philosophy. Ideas that limit benefits or enrollment for subsets of the Medi-Cal population or that increase cost-sharing will only limit care for those in Medi-Cal.

- *Protect the safety net*. Medi-Cal is the primary source of revenue for the public hospitals and clinics that care for the uninsured and those with nowhere else to turn. Public hospitals take all comers, regardless of the patient's ability to pay. Medi-Cal has an obligation to pay these providers sufficiently so that they have the resources needed for their critical mission.

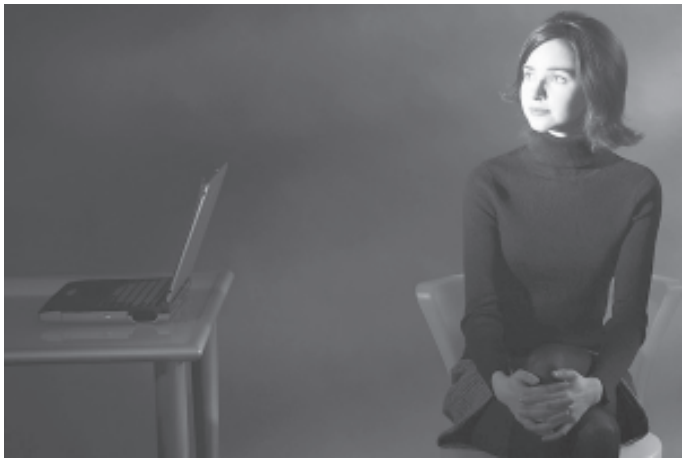
- *Raise the bar for health care quality*. Medi-Cal is a major health care purchaser in California. As such, it is uniquely positioned to give providers incentives for better care. By creating performance goals for both providers and managed care plans, Medi-Cal could set higher performance standards for providers and reduce unnecessary expenditures long term.

- *Less Paper, More Technology*. Medi-Cal must identify ways of leveraging technology to help reduce administrative costs and improve patient care.

- *Long-Term Vision*. Medi-Cal programs have evolved gradually over decades. Meaningful reform will take time and may require investments. Policymakers should not resist wise expenditure of additional funds on Medi-Cal even though they may not pay off immediately.

Focus on Critical Action Areas for Medi-Cal

- ***Improving Outreach and Enrollment.*** Of the more than one million uninsured children in California, about half are eligible for either Medi-Cal or Healthy Families but not enrolled. Over the last several years, the state has systematically eliminated Medi-Cal outreach spending in an effort to control overall expenditures for the program. The Governor's current budget contains some resources wisely targeted toward application assistance for clinics and hospitals that come in contact with eligible but unenrolled patients. However, this is available only because of undertakings from the Anthem-WellPoint merger and does not constitute a complete and effective outreach program.



The state must do a better job at identifying and enrolling people eligible for Medi-Cal and Healthy Families. As detailed below, increasing federal participation in California's Medi-Cal program would help offset the state's significant disincentive to enroll more recipients.

Important work on how best to increase outreach and enrollment has already been done by the 100% Campaign and PICO California. These ideas, expressed in SB 437 (Escutia) and AB 772 (Chan), will make it much easier to enroll in public health insurance. These outreach and enrollment strategies include:

- *Expanding "Express Lane" techniques* that expedite enrollment of children in programs that use similar income rules such as Reduced Price Lunch. Today, Express Lane is a successful pilot project in a limited number of school districts which use the school lunch application as a Medi-Cal preliminary application.

- *Accelerating enrollment into Healthy Families*, for eligible children that apply at county offices.

- *Simplifying the existing Child Health and Disability Prevention (CHDP) Gateway*. This program allows children receiving care through CHDP to become presumptively eligible for Medi-Cal, giving the child two months of eligibility while applying for full enrollment.

- *Limiting paperwork to federal law requirements* for children and families applying for Medi-Cal and Healthy Families.

- *Simplifying annual renewal forms* and processes for Medi-Cal and Healthy Families.

➢ ***Better administrative efficiency.*** Medi-Cal spends about 7% of its dollars for administration. While this is better than the 12% average in the private sector, the 7% rate stands in stark contrast to Medicare at 2% and the low spending rate at the Veteran's Administration. The state needs to develop a more efficient system for managing administration.

- *Enrollment Processes*: In a recent report funded by the California Endowment, it was determined that Medi-Cal wasted $120 million over three years to disenroll and then reenroll 600,000 children. The study found it cost the state $180 per person to enroll beneficiaries in Medi-Cal and a managed care plan, including $28 per application to a private firm for certain activities and a $26 fee charged by health plans.

- *Investment in Information Technology*. As discussed elsewhere in this report it is critically important that Medi-Cal physicians and hospitals are subsidized adequately to stay in the mainstream of advances in information technology that will allow for electronic medical records and interconnection among clinics, emergency rooms and public hospitals.

➢ ***Moving beyond fraud protection to prudent purchasing***. Throughout its history, Medi-Cal has correctly focused on reducing fraud with varying degrees of success. But while taking action against fraud is critically important, it only addresses part of the problem. Medi-Cal needs to evolve its approach to focus on quality.

- *Hospital Quality* – Medi-Cal has a rigorous contracting program for hospitals that want to see Medi-Cal patients. This contracting process should be expanded to include quality measures – with the highest performing hospitals receiving bonuses. The lowest performing hospitals could be dropped from the program.

- *Physician Quality* – Currently doctors must submit Treatment Action Requests (TARs) to provide certain care and certain prescriptions. This is a passive and burdensome system for cost-containment. Medi-Cal should become proactive with regard to expectations of contracting physicians. Medicare is doing cutting-edge work in setting performance standards for doctors accompanied by bonuses for successful achievement. As a major health care provider, Medi-Cal has the ability and the responsibility to be equally innovative.

➢ ***Assuring funding for public hospitals, trauma centers, and clinics***. Recently, a new five-year hospital financing waiver was negotiated between California and the federal government. This new waiver will allow California to continue contracts with selected hospitals serving low-income and vulnerable populations and will replace current funding methods with new systems.

However, the ramifications of the waiver are just beginning to be clarified as this report goes to print. This waiver could fundamentally change the core of how hospitals are paid by Medicaid. While the administration has a budget projection for how much money the waiver will bring in, it is too early to know what the waiver is worth.

The administration has provided a ceiling for the available federal dollars. However, numerous new federal requirements make it difficult to quantify the level of federal support. Hospital groups, consumer advocates, and many county governments have weighed in in opposition of the waiver.

- *Hospital funding formulas should not be changed.* The waiver fails to guarantee the current hospital funding formulas. This creates a politically volatile situation among the various hospital groups, potentially factionalizing hospital positions over funding.

- *County budgets should not be used as an open-ended funding source for the uninsured.* California's counties already spend a significant amount of money on health care. They balance this responsibility with fire, police, education, and other critical activities. The waiver threatens to place an open-ended responsibility on counties. The state must take steps to work with the counties so that both the state and counties are paying their fair share.

- *Simply put, the system needs more money*. Medi-Cal is underfunded and requires greater federal support, as was granted under the waiver renewal in 2003. The funding under the waiver currently envisioned by the administration is not sufficient to cover Medi-Cal's rising costs. Public hospitals and clinics operate with razor thin margins.

- *Protect the benefits and choices of seniors and the disabled.* The waiver requires mandatory enrollment of seniors and the disabled into managed care. This vulnerable population

will have to rely on HMOs for their care. The legislature needs to ensure that these systems of care are able to respond to their unique needs before allowing mandatory enrollment to occur. The waiver requires this, even though the legislature had turned down the Governor's budget request for madatory managed care enrollment.

- ***Assuring that Medi-Cal is kept affordable.*** The current state administration has called for cost-sharing among Medi-Cal beneficiaries with incomes above the federal poverty level, charging $4 per month for each child under the age of 21 and $10 per month for adults, with a maximum of $27 per month per family.

  Cost-sharing is a very blunt tool for containing costs, especially for the Medi-Cal population. Even though the $27 a month may sound minor, it is a major cost to a family of four making $29,000 a year. The main impact of this change unfortunately will be to decrease enrollment of people who need care. Too often this will result in larger long-term expenditures.

Getting the Federal Support California Needs and Deserves

California ranks 51st in funding per Medicaid beneficiary – behind every state and Washington DC. California's congressional delegation should organize and advocate for California especially on the following items.

- *The Medicare "Clawback"* – States pay a portion of the cost for outpatient drugs needed by persons who are both enrolled in Medicare and Medicaid. In 2002, states spent an estimated $5.6 billion on prescription drugs for this population. However, under the new Medicare Modernization Act (MMA), the federal government will now cover these costs. Instead of letting states shift their spending to other parts of health care, the federal government will charge states an estimate for how much money they had been paying for these drugs. This is called the "clawback."

Under President Bush's Medicare drug plan, California is scheduled to "pay back" the federal government $1 billion over the next five years for drug benefits shifted from Medi-Cal to Medicare. Unfortunately, the amount we pay back is set at a base year that does not recognize cost efficiencies in drug purchasing. As a result, the Medicare "clawback" will be a net drain on the state's General Fund. Our system cannot withstand that type of reduction in federal support.

- *Increasing funding for the safety net* - Medi-Cal's success in maintaining low hospital and physician reimbursement rates only leads to reduced federal support. Medi-Cal is actually punished for its ability to negotiate rates. The Governor should be fighting for California to be rewarded for its achievements by working with the federal government on a bill that would increase the FMAP (Federal Medical Assistance Percentages which are used to determine the level of matching federal funds for Medicaid) for California.

Recommendations

The California State Legislature and State Government should organize to:

- Avoid cost-sharing and benefit reductions that undermine Medi-Cal's purpose and entitlement.
- Expand enrollment to include all eligible children in Medi-Cal and Healthy Families.
- Increase administrative efficiency within Medi-Cal to at least the level achieved in Medicare.
- Create pay-for-performance incentives within Medi-Cal and increase quality through state of the art initiatives.
- Advocate for a fair share of federal assistance for Medi-Cal.

Resources

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Chapter 5: Prescription Drugs

The State of Prescription Drugs

- US prescription drug spending totaled $179.2 billion in 2003, a more than four-fold increase from the amount spent in 1990.
- Although still only a modest part (11%) of overall health care spending, prescription drug spending has consistently been one of the fastest growing sectors of health care, experiencing double-digit growth rates in each of the past eight years.
- The rising cost of prescription drugs impacts both coverage and affordability, most notably for seniors and the poor. Rising costs are having a direct negative impact on health outcomes.
- State Medicaid spending on prescription drugs grew from $17 billion in 1999 to $30 billion in 2003 with $17 billion being for dual eligibles (people eligible for both federal Medicare and state Medicaid programs).
- The federal government's exposure to prescription drug increases will grow significantly with implementation of the Medicare Modernization Act. The Medicare prescription drug benefit will cost $849 billion over the next 10 years according to the latest Congressional Budget Office projections.
- The pharmaceutical industry was the most profitable industry in the US from 1995 to 2002 and ranked as the third most profitable in 2003 with after-tax profits of 14 percent.
- US consumers routinely pay 50% to 100% more than those in other countries for many common prescription drugs.

The unprecedented growth in prescription drug prices is the result of multiple factors including:

- abuse and overuse of patent laws;
- lack of transparency;
- oligopolistic behavior and lack of competition among pharmaceutical companies;
- pharmaceutical direct advertising to physicians and consumers;
- an aging population;
- more expensive replacement drugs;
- and a shift in health care from primarily treating acute illness toward helping people live with chronic illness.

Issues, Challenges and Opportunities

Patent Law and Generics

Patent laws protect pharmaceutical manufacturers from competition, forcing consumers to pick up the high cost of brand name drugs. While this practice is defended by the pharmaceutical industry to protect investments in research and development, widespread abuse of patent law is helping to fuel the current prescription drug cost crisis.

Pharmaceutical companies routinely employ a number of strategies to extend the life of their patents and prevent generic competition. For example, there is "evergreening," the practice of securing new patents with minor, cosmetic changes on patent-expiring drugs to effectively extend the life of the patent and prevent generic competition. Companies can file appeals to extend a stay on the termination of a patent for 30 months and they will frequently "stack" such stays one after another. The 180-day generic exclusivity provision aimed at getting generic drugs to market quickly is abused by pharmaceutical companies who pay generic companies not to go to market – further delaying access to generic drugs. The federal government, in cooperation with the states, should clean up these abuses and push to make generic drugs available as quickly as possible.

The federal government also needs to map out an effective plan to ensure that consumers will have access to generic biologics. Biologics are very expensive, protein-based complex molecule drugs like insulin, Epogen (epoetin alfa) and Remicade (infliximab) that show enormous promise for treating conditions and diseases previously thought untreatable (including some genetic disorders). The lack of generic substitutes for biologics could create a fiscal nightmare for both public and private insurers. It is especially important for the new Medicare drug benefit which will cover these drugs for large numbers of patients.

A 2003 Federal Trade Commission (FTC) report proposed a series of legislative and regulatory changes to improve patent law. One recommendation is to establish a new administrative procedure that make it easier to challenge a patent's validity without engaging in expensive, time-consuming litigation (on average, patent challenges cost more than $1 million). The FTC report also recommends lowering the standard of proof to overturn a patent from "clear and convincing evidence" to "preponderance of the evidence." This new standard would infuse competition by making it substantially easier for generic companies to begin producing off-patent drugs. Federal adoption of the FTC recommendations should be fast-tracked.

Transparency in PBMs

PBMs (Pharmaceutical Benefit Managers) are private companies that administer most of the outpatient prescription drug benefits for the majority of the 160 million people who have employer-based health coverage, as well as for many Medicaid beneficiaries. Although there are forty to fifty PBMs of meaningful size, three PBMs – Caremark, Medco, and Express Scripts – dominate the market, managing more than one-third of the $208 billion in annual US drug spending. As the size of the industry has expanded, PBMs have increased control over formularies and pricing in the commercial sector.

Despite their increasing influence, PBMs remain relatively unregulated. But the calls for regulation and transparency continue to grow. Over the past year, the majority of state attorneys general have initiated investigations and/or filed lawsuits against PBMs questioning their business practices. Large employer coalitions are trying to loosen PBM control over pricing and shed light on their rebating policies. Thirty-two states have considered laws to regulate PBMs in the past two years and six states have passed legislation, primarily requiring licensure and targeted data reporting on business dealings. California Assemblywoman Fran Pavley (Agoura Hills) is carrying a bill in the 2005–06 legislative session regarding PBM transparency. Effective legislation in this area must strike a balance between the need to insure that PBMs are acting in their customers' best interest and the need to preserve the requisite confidential environment for PBMs to negotiate effectively.

The Medicare Modernization Act (MMA) will open the Medicare market to PBMs without new transparency requirements. Perhaps more troubling is the large degree of responsibility for implementation of the new prescription drug benefit the Act gives to the industry.

Rebating

Rebates can be a seductive trap. A 50% discount even for a drug that may not be the most effective or economical can be attractive. Unfortunately formularies are often constructed by chasing rebates instead of using information on clinical outcomes. There are too many examples of a high-priced, brand-name product being used when an equally efficacious generic substitute is available. (example: Nexium v. generic Prilosec, and Lipitor v. generic lovastatin). More transparency in PBMs drug rebating arrangements with pharmaceutical manufacturers might help clarify the depth of this problem.

Similarly, the federal government, with encouragement from state governments, should amend the Medicaid drug rebate program by replacing the current "best price" formula (OBRA 90) with a flat percentage formula. Because drug manufacturers are required to provide their "best prices" to state Medicaid programs, they no longer have the incentive to negotiate and offer steeper discounts to other purchasers (since they would have to offer the same price to Medicaid). As a result, the "best price" formula inadvertently established a price support for brand-name pharmaceuticals which has only served to inflate drug prices and remove incentives for proper pharmaceutical benefit management. A flat percentage formula designed to generate approximately the same amount of revenue for government could achieve the same goals, but eliminate the price floor.

Drug Formulary Design

A drug formulary is a list of preferred pharmaceutical products that health plans, working with PBMs, pharmacists and physicians, develop to be used by the plan's members. Ideally, the formulary is developed balancing medical efficacy, drug safety and cost-effectiveness as the primary criteria. But the all-or-nothing nature of contracting with manufacturers in formulary design encourages rebate chasing, drives some manufacturers out of markets and undermines long-term competition. The result is an imbalance in formulary design favoring cost-savings and profit maximization over drug efficacy.
A successful formulary system, like that of Kaiser Permanente, has certain criteria. First, drug formularies must be driven primarily by clinical experience and medical efficacy. Second, physicians must have a stronger voice and more input in the formulary development process. Physicians must be supported in

prescribing with information on the latest developments and EMR. Third, formularies must be revisited constantly and designed to encourage competition among manufacturers and distributors. Finally, generic equivalents should be used whenever possible.

Direct-to-Consumer (DTC) advertising

The pharmaceutical industry spends more than $3 billion each year directly marketing drugs to consumers. A 2003 Harvard/MIT study estimated that increases in DTC advertising in 2000 accounted for a 12% growth in drug sales that year. The study also projected that every $1 invested in DTC advertising yielded an additional $4.20 in sales. DTC advertising accounts for 14% of prescription drug marketing, with 86% of promotional activity focused on physicians (detailing and drug sampling). This cost passed on to consumers provides no clear gain in quality of care.

Detailing

Directly marketing high-margin, brand-name drugs to physicians (detailing) increases the utilization and the cost of drugs. Physicians impact consumption patterns through 'power of the pen' when they prescribe. Without credible independent information about drug efficacy, physicians are overly dependent on drug company detailers for essential information. Many physicians continue to prescribe patented brand-name drugs when appropriate generic substitutes are available (example: generic ibuprofen v. Celebrex/Vioxx). The state can play a stronger role in influencing physicians to take more responsibility for cost-effective prescribing. Quality and technology initiatives that are dealt with in a separate part of this report can significantly impact this problem, as can properly applied incentives.

Drug Efficacy

There are virtually no studies conducted to evaluate the comparative efficacy of drugs in the same class. This is in part due to the fact that the FDA evaluates drugs in comparison to placebos rather than similar drugs. Without comparative studies, physicians are more vulnerable to pharmaceutical industry marketing strategies. Funding independent comparative drug studies and compiling and publishing this data would allow the government to play a significant role in controlling costs and educating the public.

Importation

Permitting the importation of drugs from other countries, primarily Canada, is a popular panacea to control costs. The policy is aimed at preventing drug companies from routinely charging US customers 50% to 100% more than customers in most other countries for the same drug.

Importation is at best a short-term solution primarily benefiting wholesalers and other arbitragers. This is because without parallel international efforts, drug companies will simply respond by segmenting markets and manipulating supply. These strategies will prevent downward pressure on prices and profit margins. Facing the threat of having their own drug supplies reduced by drug manufacturers, foreign governments are resisting the use of their negotiating clout to subsidize US citizens. Ultimately, state

and federal energy is probably best spent making use of volume purchasing clout instead of appropriating the benefits of other country's price control schemes. However, provisions of the Medicare Modernization Act bar the federal government from using its significant purchasing power to negotiate with pharmaceutical companies for lower drug prices.

Wholesaling and Counterfeiting

The high price of prescription drugs combined with the desperate need of Americans to obtain them has created a rapidly growing, multi-billion dollar shadow market for prescription drugs in the United States. That market threatens the safety, quality and integrity of what has historically been regarded as the safest and highest quality market in the world. This shadow market exploits lax state and federal regulation of Medicare and wholesale pharmaceutical distributors. Groups of small brokers (drug "diverters") illegally gain control of billions of dollars worth of discounted medicines intended for nursing homes, hospices, and AIDS clinics. As they pass from wholesaler to wholesaler these drugs are marked up and their safety and quality is compromised by inadequate storage conditions, the passage of time, and fraudulent branding. The "big three" drug wholesalers - Cardinal Health, McKesson Corp., and AmerisourceBergen – have all been implicated in trafficking in illegal and counterfeit drugs. The Internet is facilitating the growth of illegal wholesaling and counterfeiting.

In 1988, Congress passed the Prescription Drug Marketing Act which attempted to stop diverters by creating a paper trail 'pedigree' to document the sales path of a drug. Efforts to implement this law by the FDA have been thwarted over the past 17 years. Small wholesalers argue that the administrative burden of compliance will put them out of business. Florida has been at the forefront of drug-pedigree legislation, passing a law in 2003 that will take effect in July 2006. The wholesale industry is continuing its efforts to stall and water down implementation of Florida's drug-pedigree law.

Recommendations

Many of the reforms necessary to improve quality and drive down the costs of prescription drugs require solutions on the federal level. However, as discussed above, there is plenty that can be done at the state level to help educate the public and put downward pressure on prescription drug prices.

State government can:

- Push to make generic drugs available on as timely a basis as possible.
- Increase oversight of PBMs, specifically requiring more transparency in their drug rebating arrangements with pharmaceutical companies, while preserving the ability of PBMs to negotiate favorable prices on their customers' behalf.
- Fully leverage purchasing power of state programs to negotiate better rebates and prices from pharmaceutical manufacturers.
- Help fund more independent comparative drug studies and serve as a clearinghouse for drug efficacy information, perhaps through the UC system.

- Support price competition by avoiding new laws that discourage drug price negotiation, such as unitary pricing and "best price"-type requirements that operate as floor price controls.

- Regularly review drug use patterns in the Medi-Cal program to ensure that incentives created by Medi-Cal rebates do not lead to the use of more expensive drugs, resulting in higher overall drug prices.

- Explore legislation that would place limits on DTC advertising.

- Encourage the physician community to take more ownership and responsibility to engage in more cost-effective prescribing.

- Step up regulatory enforcement of the drug wholesaling market by strengthening and coordinating state licensing requirements with other states, investing in more inspectors, developing drug-pedigree laws, and exploring packaging options to prevent counterfeiting.

Resources

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Chapter 6: Public Health/Prevention

No discussion of the state of health care in California is complete without a look at public health – the commitment to protect all Californians and their communities from preventable, serious health threats, to assure community-based health promotion and disease prevention activities, and to guarantee preventive health services are universally accessible.

Healthy People 2010 is an effort led by the federal government to set goals on improving public health. In April 2005, the California Department of Health Services released an initial assessment of the state's progress in meeting 62 of the Healthy People 2010 public health indicators. While California is performing on par with or better than other states, this is only part of the picture. If measured against historical performance, California is trending the wrong way on many public health indicators:

- The number of low birth weight (LBW) babies born in California is increasing. The rate of LBW per live births has gone from 6.2% in 2000 to 6.6% (or 35,000 total) in 2003.

- California deaths due to HIV – 1,351 in 2003. California has made improvements in this area, but much remains to be done.

- California deaths due to firearms – 3,326 in 2003, an increase from 9.2 per 100,000 in 2000 to 9.6 per 100,000 in 2003.

- Hospitalization for asthma among the adult population 65 and older continues to escalate. In 2003, there were 8,060 discharges up from 6,323 the previous year. While the target set by Healthy People 2010 is 10 per 10,000 population, African Americans aged 65 and over experienced the highest asthma hospitalization rates (34.0 per 10,000 in 2003), followed by Hispanics/Latinos (30.0 per 10,000 in 2003).

- Maternal deaths due to obstetrical care in California have also increased from 9.7 per 100,000 in 2002 to 10 per 100,000 in 2003. The Healthy People target is 3.3.

Throughout history, public health and public health infrastructure account for the most significant gains in life expectancy. Immunization, sanitation, and education efforts have produced immeasurable benefits for society as a whole. A renewed focus on community health and wellness is essential if we are to succeed in controlling cost and expanding access to health care. Relatively simple programs can improve wellness and avoid the need for more expensive medical care.

Some of California's most significant public health challenges have already been discussed in this report — the ongoing difficulties caused by obesity, diabetes, and asthma; the high level of infant mortality in certain California areas; and the persistent and growing level of health disparities among California's

racial and ethnic groups. Solving these problems will require a concerted investment in traditional public health programs, including education and health promotion programs emphasizing nutrition, exercise and the importance of preventive health efforts.

In addition, to traditional public health concerns, increasing and un-quantified pressures will be put on our public health infrastructure by: global travel, that subjects our population to diseases that were formerly geographically isolated such as SARS and avian flu; climate change, that brings with it the possibility of increasing disease and catastrophe; and the possibility of terrorism.

Bioterrorism

Since 9/11, bioterrorism has become a high-profile public health issue. As a result, funding from the Center for Disease Control and other sources has been directed to local communities for preparedness efforts. Bioterrorism may manifest in different forms from catastrophes requiring HAZMAT teams to slowly spreading epidemics. By now it is clear that the traditional public health "astute physician" — who recognizes the beginnings of a pattern of infection — remains one of the most important first responders.

Concern is growing that bioterrorism preparedness that includes targeted mandates like smallpox vaccinations is diverting resources from core public health functions, such as routine immunization, health promotion and screening.

With the wide range of potential threats to public health, funding and guidelines for preparedness efforts should focus on broad infrastructure changes that support rather than undermine traditional public health prevention and promotion efforts. States and localities will likely need ongoing dedicated funds to build and maintain bioterrorism preparedness capacity. Without continuing financial support, activities that require more than a one-time investment, such as training the health care workforce and upgrading of information systems, will fall short.

Furthermore, California must take the necessary steps to ensure that it is prepared to respond to the many challenges the state could face if the tragedy of a bioterrorism or natural epidemic event occurs. A recent report by California's Little Hoover Commission reached the same conclusion, criticizing California for lacking a clear state plan to mobilize large numbers of medical personnel, distribute drugs or communicate among first

responders and health workers in the event of a large epidemic or terrorist attack. Health care experts have warned that without clear leadership, California will quickly be outpaced by a fast spreading outbreak.

Human Immunodeficiency virus (HIV)

In 2003, there were 1,351 deaths in California due to HIV.

Preventing the spread of HIV and treating those with this deadly disease is one of California's most important public health issues. And it presents a clear picture of how important public education is to public health. While the steps to educate the public and reduce the spread of the disease are relatively inexpensive, the prescription drugs alone that are needed to treat HIV can cost tens of thousands of dollars a year per individual.

Healthy People 2010 targets the rate of death from HIV at 0.7 deaths per 100,000 people. While California's rate is slowly trending in the right direction, we still have a long way to go. The rate of death from HIV has only dropped from 4.4 in 2000 to 3.9 in 2003.

As is the case for many of the public health indicators, HIV is of significant concern to the African American community which had the highest death rate among ethnic groups at 13.8 per 100,000 in 2003. Whites ranked a very distant second at 3.5 per 100,000 population.

Fire-Arms in California

In 2003, there were 3,326 California deaths due to firearms.

The emotional and fiscal costs of death by firearms are astounding. In 1997, the cost for an emergency room treatment for a gunshot wound averaged $73,000. Considering the rate of medical inflation, today's figure could easily exceed $100,000. Specific anecdotal information puts care and recovery for some gunshot victims into the millions. Healthy People 2010 sets a goal to reduce the rate of death from gunshot wounds to 4.1 per 100,000 people. Unfortunately, California continues to move in the opposite direction. The rate has gone up from 9.2 per 100,000 people in 2000 to 9.6 in 2003.

The racial disparity here is striking. African Americans had the highest age-adjusted firearms-related death rate at 26.7 in 2003. Again, whites ranked a very distant second among ethnic groups at 8.4 in 2003.

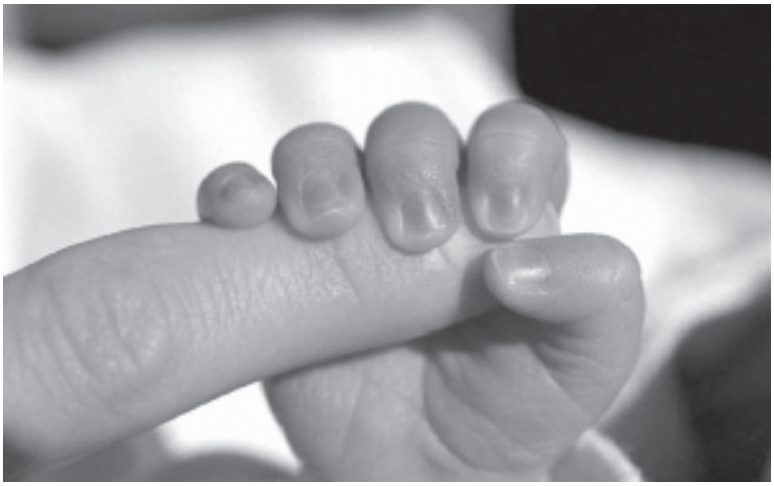
Low Birth Weight Babies

In 2003, there were more than 35,000 low birth weight babies (LBW) born in California (LBW defined as less than 2,500 grams).

This is a critical problem for both the baby and the family. These families face much higher short-term health costs, including pediatric intensive care. More importantly, studies and experience indicate that LBW babies are less likely to graduate high school and college and will typically have lower IQs on average in adulthood as compared to babies born at normal weights.

Healthy Families 2010 targets the reduction of LBW births to 5% of live births. Again, California is moving in the wrong direction. The ratio of LBW births in California has gone from 6.2% in 2000 to 6.6% in 2003. Better pre-natal care for the mother and better education on the activities that can help the baby from birth are just two ways to help reduce the number of LBW babies.

Once more, the racial disparity is startling. The LBW ratio for African Americans in California was 12.6%. Asians ranked second among ethic groups at 7.3% in 2003.



Recommendations

Investment in public health offers the best promise for significant returns – creating healthy communities and reducing overall health care costs. Many recommendations in earlier chapters aim at achieving public health objectives, and of course many of these problems would be more effectively addressed in a universal health care system. The recommendations below are also essential:

- Achieve public health goals set by the Healthy People 2010 program and commit resources to California communities where public health indicators are deteriorating.
- Improve pre-natal care, especially for low-income individuals.
- Ensure that seniors and vulnerable Californians have access to the flu vaccine.
- Increase the level of childhood immunization.
- Expand efforts to prevent the spread of HIV.
- Enhance California's public health administration. Consider options for creating a single state agency responsible for public health.
- Develop innovative solutions for "healthy communities" where residents can exercise outdoors safely and have access to grocery stores with fresh fruit and vegetables.
- Use Medi-Cal to promote and incentivize healthy lifestyles.
- Create private-public partnerships where employers help promote wellness.
- Strengthen and improve steps already taken to ensure that California schools offer a range of healthy, affordable food choices.
- Assure that school nurses are available in school districts throughout California. School nurses can detect and help prevent early outbreaks of childhood disease, evaluate nutritional and physical exercise needs and assess the overall health of the student body. This goal can be achieved by committing resources to fair salaries and benefits, and by providing incentives such as tuition waivers to student nurses willing to work in selected school districts.
- Ensure that bioterrorism issues are being fully addressed without compromising the budget for other core public health functions.
- Target resources for comprehensive efforts to end public health disparities among different socio-economic and racial groups.

Resources

California State Department of Health Insurance, Healthy People 2010: http://www.dhs.ca.gov/hisp/chs/ohir/hp2010/reports.htm

American Public Health Association: http://www.apha.org

Trust for America's Health: http://www.tfah.org

Southern California Public Health Association: http://scpha.org/

California Public Health Association – North: http://www.cphan.org/

Center for Public Health Advocacy: http://www.publichealthadvocacy.org

Kaiser Family Foundations' State Health Facts: http://www.statehealthfacts.org

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Rand Health Technical Report Public Heatlh Preparednesss in California: Lessons Learned from Seven Health Jurisdictions, Nicole Lurie, R. Rurciaga Valdez, Jeffrey Wasserman, Michael Stoto, Sarah Myers, Roger Molander, Steven Asch, B. David Mussington, Vanessa Solomon, August 2004

Appendix 1:
Summary of Recommendations

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Chapter 2: Benefits and Cost Sharing

- Establish Knox-Keene benefits plus prescription drugs as the common benefit floor for all HMOs and health insurance policies sold after approval at the Department of Insurance. Conduct a public review of the impacts of consumer-driven plans. The benefit floor cannot be breached until we understand the implications of the consumer-driven plans.

- As a condition of contracting with the state of California, employers must, at a minimum, provide a "Knox-Keene plus prescription drugs" or equivalent comprehensive benefit package to all employees.

- Strengthen rate review with emphasis on reviewing administrative expenditures.

- The federal government should reimburse qualifying companies and insurers for 75% of the portion of any claim exceeding $50,000. By creating federal reinsurance for catastrophic claims, premiums could be kept more affordable for businesses and individuals without compromising comprehensive benefits.

- Require hospitals to calculate and disclose on each bill they issue, the percentage and dollar amount of cost shifting for uncompensated care incorporated in the final charge that is associated with each billed service.

Chapter 3: Improving the Quality of Health Care

- Require licensure standards for health facilities, both public and private, to include participation in data collection efforts, quality assessment programs, 'best practice' programs, and other quality incentives.

- Endorse and facilitate compliance with the national standard for Health Information Technology by funding CalRHIO.

- Within 10 years, provide EMR capability in all medical settings and revise any laws or other barriers that would hinder an insurer from providing hardware and software to providers.

- Create subsidies for small medical practices and safety net providers to assure that they remain on even footing with larger segments of the medical community in implementing quality initiatives and deploying information technology.

- Review and revise regulations for health care facilities to require the use of evidence-based medicine.

- Establish a pay-for-performance program within Medi-Cal with appropriate financial support for subsidies for providers to gain access to necessary tools, technology, and information.
- Assure nursing staff ratios are met and expand the use of nurses throughout the industry.
- Involve nurses and nurse practitioners in the development of quality standards.
- Expand community college and university nurse training resources.
- Reward nurses and encourage entry into the profession with adequate pay and other incentives.
- In conjunction with DMHC, license a data collection point for PPOs and HMOs to aggregate data on treatment and outcomes.
- Approve discounts or credits by medical malpractice insurers for physicians with CPOE and EMR capabilities.
- Seek legislation to require PPO CEOs to adopt a common set of quality metrics for PPOs and to participate in CalRHIO.

Chapter 4: Medi-Cal Reform

The California State Legislature and State Government should organize to:

- Avoid cost-sharing and benefit reductions that undermine Medi-Cal's purpose and entitlement.
- Expand enrollment to include all eligible children in Medi-Cal and Healthy Families.
- Increase administrative efficiency within Medi-Cal to at least the level achieved in Medicare.
- Create pay-for-performance incentives within Medi-Cal and increase quality through state of the art initiatives.
- Advocate for a fair share of federal assistance for Medi-Cal.

Chapter 5: Prescription Drugs

Many of the reforms necessary to improve quality and drive down the costs of prescription drugs require solutions on the federal level. However, there is plenty that can be done at the state level to help educate the public and put downward pressure on prescription drug prices.

State government can:

- Push to make generic drugs available on as timely a basis as possible.
- Increase oversight of PBMs, specifically requiring more transparency in their drug rebating arrangements with pharmaceutical companies, while preserving the ability of PBMs to negotiate favorable prices on their customers' behalf.
- Fully leverage purchasing power of state programs to negotiate better rebates and prices from pharmaceutical manufacturers.
- Help fund more independent comparative drug studies and serve as a clearinghouse for drug efficacy information, perhaps through the UC system.
- Support price competition by avoiding new laws that discourage drug price negotiation, such as unitary pricing and "best price"-type requirements that operate as floor price controls.
- Regularly review drug use patterns in the Medi-Cal program to ensure that incentives created by Medi-Cal rebates do not lead to the use of more expensive drugs, resulting in higher overall drug prices.
- Explore legislation that would place limits on DTC advertising.
- Encourage the physician community to take more ownership and responsibility to engage in more cost-effective prescribing.
- Step up regulatory enforcement of the drug wholesaling market by strengthening and coordinating state licensing requirements with other states, investing in more inspectors, developing drug-pedigree laws, and exploring packaging options to prevent counterfeiting.

Chapter 6: Public Health

Investment in public health offers the best promise for significant returns – creating healthy communities and reducing overall health care costs. Many recommendations in earlier chapters aim at achieving public health objectives, and of course many of these problems would be more effectively addressed in a universal health care system. The recommendations below are also essential:

- Achieve public health goals set by the Healthy People 2010 program and commit resources to California communities where public health indicators are deteriorating.
- Improve pre-natal care, especially for low-income individuals.
- Ensure that seniors and vulnerable Californians have access to the flu vaccine.
- Increase the level of childhood immunization.
- Expand efforts to prevent the spread of HIV.
- Enhance California's public health administration. Consider options for creating a single state agency responsible for public health.
- Develop innovative solutions for "healthy communities" where residents can exercise outdoors safely and have access to grocery stores with fresh fruit and vegetables.
- Use Medi-Cal to promote and incentivize healthy lifestyles.
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- Assure that school nurses are available in school districts throughout California. School nurses can detect and help prevent early outbreaks of childhood disease, evaluate nutritional and physical exercise needs and assess the overall health of the student body. This goal can be achieved by committing resources to fair salaries and benefits, and by providing incentives such as tuition waivers to student nurses willing to work in selected school districts.
- Ensure that bioterrorism issues are being fully addressed without compromising the budget for other core public health functions.
- Target resources for comprehensive efforts to end public health disparities among different socio-economic and racial groups.

Appendix 2:
Matrix of Selected Uninsured Proposals in California

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Prepared by Insure the Uninsured Project
www.itup.org
April 1, 2005

Universal Coverage – Current Legislation

Legislation	Eligible	Benefits	Cost controls	Financing	Who administers	Employer impacts
SB 840 Kuehl	All California residents eligible	All benefits, except nursing home care	Regulation of prices, elimination of health plans, bulk purchasing and cap on program growth Shifts to fee for service reimbursement	$70 billion in taxes to replace out of pocket costs and premiums. All existing spending for public health programs	State health agency as single payor	Replaces employer premiums with payroll taxes
AB 1670-1675 Richman and Nation	Mandates that all California residents under age 65 buy or enroll in available coverage	Full scope standard commercial coverage for persons with incomes below 200% of FPL Catastrophic care ($5000 deductible) and preventive care for persons with incomes above 200% of FPL	Regional purchasing pools, electronic enrollment, program simplification, delay in hospitals' seismic safety upgrades, Center for Quality Medicine	Gross premium tax applies to all health plans Funding priorities: uninsured children, Healthy Families parents and subsidies for low wage small employers	State health agency, purchasing pool and health plans	Subsidizes uninsuring, small low-wage employers

Appendix 2: Matrix of Selected Uninsured Proposals in California

Prepared by California Department of Insurance

Universal Coverage – Other Proposals

Legislation	Eligible	Benefits	Cost controls	Financing	Who administers	Employer impacts
California Medical Association 4 tiers	Uninsured with income >400% of FPL	Catastrophic + preventative	Community rating or high risk safety net pool	Individual mandate, possible public support	Insurance companies	Replaces employer premiums
	Uninsured children < 18 in households earning < 200% of FPL	SCHIP or Medicaid coverage	Fee schedules	Public funding; Federal dollars	Department of Health Services	None
	Uninsured with incomes betw. 200%-400% FPL	Catastrophic + preventative	Not first dollar coverage except for preventative care	Refundable Tax Credits on sliding scale	Insurance companies	Some employers may stop providing health insurance to low income workers
	Uninsured with income under 200% FPL	Full scope Medicaid services		New federal medical tax based on income for those in health care plans valued at > 110% of average actuarial-valued benefit package	Department of Health Services	May pressure employers to make up for tax on health care benefits
Blue Shield Proposal	Universal coverage	Essential benefits, including preventive care and prescription drug coverage	Evidence-based medicine	Employers provide or pay a tax – 75% for e'ees, 50% for dependents or 7% of payroll; Employees must have coverage – paying difference. Low income e'ees get subsidy Individuals too. Gov't must enroll all eligible	Insurers using community rating – no pre-existing condition exclusions; Department of Health Services	Employers not currently providing health care will now pay in. Employers currently paying will save money

Appendix 2: Matrix of Selected Uninsured Proposals in California,

Prepared by Insure the Uninsured Project
www.itup.org
April 1, 2005

Children's Health Coverage – Current Legislation

Legislation	Eligible	Benefits	Cost controls	Financing	Who administers	Employer impacts
AB 772 Chan **SB 437 Escutia**	All uninsured California children eligible to enroll in either MediCal or Healthy Families as applicable Bright line between programs at 133% of FPL	Full scope MediCal Full scope Health Families, includes dental and vision services	Streamlines public program's application and renewal processes for children Moves primary care for the uninsured from the emergency room to the doctor's door	Federal match, state General Fund, parent contributions Parents pay on a sliding fee scale and at full premium cost over 300% of FPL Consolidation/coordination of existing program funds Estimated additional cost of $100-$300 million, depending on extent of consolidation with existing programs Coordinates existing programs with Healthy Kids programs during interim	Department of Health Services, Managed Risk Medical Insurance Board contract with public and private health plans	Voluntary employer partici-pation option
SB 38 Alquist	Uninsured children with incomes 250-300% of FPL eligible to enroll in Healthy Families	Full scope Healthy Families, includes dental and vision services	Substitutes federal and state funds for local funds	Federal match and state General Fund	Managed Risk Medical Insurance Board contracts with public and private health plans	None

Appendix 3:
Health Care Forum Participants

Appendix 3: Health Care Forum Participants

Note: The ideas and opinions expressed in this report are solely those of Insurance Commissioner John Garamendi and his staff. While many of these ideas and opinions were developed, in part, from discussion during a series of health care meetings sponsored by the Commissioner, they do not and are not intended to represent a concensus of the diverse views and opinions held by the forum participants.

November 23, 2004
Discussing an Essential Health Care Benefits Package

- Linda Bergthold, Watson Wyatt Worldwide
- Anne Eowan, ACLHIC
- Assemblywoman Rebecca Cohn
- Duane Dauner, CHA
- Angie Wei, CA Labor Federation
- Beth Capell, Health Access
- Dave Benson, CA Association of Health Underwriters
- William Whitely, United Health Care Group
- Dennis Flatt, Kaiser Permanente
- John Puente, DMHC
- Michael Johnson, Blue Shield of California
- Peter Harbage, USC
- Debbie Roth, Assemblymember Dario Frommer's Office

December 10, 2004
Government's Role in Controlling the Cost of Prescription Drugs

- Sharon Levine, Kaiser Permanente
- Kathryn Duke, Medpin
- Rick Smith, PhRMA
- Jarvio Grevious, CalPERS
- Bob Warnagieris, AARP
- Liz Doyle, California Labor Federation
- Anne Eowan, ACLHIC
- Soap Dowell
- Peter Harbage, USC
- Debbie Roth, Assemblymember Dario Frommer's Office
- Richard Thomason, Assemblymember Dario Frommer's Office

January 14, 2005
Necessary Quality-Assurance Measures

- Reed Tuckson, United Health Group
- Michael Ralston, Kaiser Permanente
- Carl Volpe, WellPoint
- Beau Carter, Med-Vantage Inc.
- Terrigal Burn, Palo Alto Medical Clinic
- Azhar Qureshi, St. Joseph Health System
- Lucy Johns, Healthcare Planning and Policy
- Tom Moore, Jr., California Works Foundation
- Ron Bangasser, CMA
- Ellen Badley, DMHC
- Bob Warnagieris, AARP
- Anne Eowan, ACLHIC
- Anthony Wright, Health Access
- Beth Capell, Health Access
- Peter Harbage, USC
- Debbie Roth, Assemblymember Dario Frommer's Office

January 28, 2005
Publicly-Financed Health Care Delivery

- Kim Belshe, California Health and Human Services Agency
- Bruce Bronzan, Trilogy Intergrated Resources
- Jack Lewin, CMA
- Denise Martin, California Association of Public Hospitals and Health Systems
- Carmela Castellano, California Primary Care Association
- John Monahan, WellPoint
- Dave Kears, Alameda County Health Care Services Agency
- Angela Gillard, Western Center on Law and Poverty
- Lesley Cummings, Managed Risk Medical Insurance Board
- Lucy Johns, Healthcare Planning and Policy
- Kathleen McKenna, Kaiser Permanente
- Peter Harbage, USC
- Debbie Roth, Assemblymember Dario Frommer's Office

Health Care Forum Participants

February 11, 2005
Long Term Solutions to Financing Health Care and Cost-Control

- Bruce Bodaken, Blue Shield of California
- Robert Hertzka, CMA
- E. Richard Brown, UCLA
- Rick Kronick, UCSD
- Larry Levitt, Kaiser Family Foundation
- Judy Spelman, Senator Sheila Kuehl's Office
- Lucien Wulsin, Insuring the Uninsured Project
- Walter Zelman, USC
- Mark Smith, CA Health Care Foundation
- Tom Moore Jr., California Works Foundation
- Azhar Qureshi, St. Joseph Health System
- Anne Eowan, ACLHIC
- Ellen Badley, DMHC
- Peter Harbage, USC

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